Family Care Quality

CMO Member Outcomes:

The 2001 Assessment

April 2002

Department of Health and Family Services
Office of Strategic Finance
Center for Delivery Systems Development

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Summary

The Department of Health and Family Services is using several methods, both traditional and innovative, to measure and assure quality in Family Care, Wisconsin's redesigned system of long-term care for elderly individuals and individuals with physical or developmental disabilities. Traditional methods of quality assurance include procedures such as monitoring the local care management organizations' (CMOs) compliance with contract requirements and reviewing complaints and grievances.

The quality of Family Care services is also being assessed with an innovative method based upon 14 Family Care "member outcomes," which will enable the Department and the CMOs to ensure that the long-term care services are in fact producing results that are desired by each consumer. These outcomes were identified by a group of consumers, providers, advocates, and staff of the Department's Center for Delivery Systems Development, Bureau of Developmental Disability Services (BDDS), Bureau on Aging and Long-Term Care Resources (BALTCR), and Division of Health Care Financing.

Family Care Member Personal Outcomes

Detailed explanations of each of these outcomes can be found on page 6.

Self-determination and choice outcomes

1. People are treated fairly.
2. People have privacy.
3. People have personal dignity and respect.
4. People choose their services.
5. People choose their daily routine.
6. People achieve their employment objectives.
7. People are satisfied with services.

Community Integration outcomes

8. People choose where and with whom they live.
9. People participate in the life of the community.
10. People remain connected to informal support networks.

Health and Safety outcomes

11. People are free from abuse and neglect.
12. People have the best possible health.
13. People are safe.
14. People experience continuity and security.

Because individuals have personal preferences, different services are needed to achieve the same outcome for different people. For example, satisfaction of the outcome "People have a choice about where and with whom they live" would require different services for an individual who prefers living alone and an individual who prefers a congregate setting, although each might be residing in housing that appears safe and appropriate to others.

This report contains the results of the second series of Family Care member-outcome interviews with 492 randomly selected CMO members and their care managers. In conversations with these members conducted between May 2001 and November 2001, trained interviewers determined whether each outcome was present in each member's life. The members' care managers were also interviewed to determine whether the CMO had identified each member's preferences for each outcome and was providing the member with services or supports to assist the member in achieving the outcome.

The interviewers were trained in assessment techniques developed by the Council on Quality and Leadership (the Council), a nationally recognized authority for the accreditation of long-term care programs for people with disabilities. These techniques, which the Council has been refining for more than ten years for use with people with disabilities, were adapted for use in Wisconsin in consultation with the Council. BALTCR staff were helpful in refining the interview questions and techniques for use with elderly individuals. For example, the outcome, "People achieve their employment objectives" was framed for elderly individuals to assess whether they were involved in daytime activities that they considered meaningful and fulfilling. Additional efforts are underway to ensure that these outcomes have values and relevance for elderly individuals.

The results presented here show, for each of the 14 outcomes, the proportion of interviewed members for whom their desired outcomes were present (outcomes present) and the proportion of interviewed members for whom the CMOs were found to be providing supports tailored to achieve those outcomes (supports provided.)

These results cannot be considered to be a numeric report card of the CMOs' performance for several reasons. First, the Department has not yet identified benchmarks or targets for each outcome. No one can expect complete attainment of all outcomes—it is unrealistic to expect that all desired outcomes will be present at any given time for any individual, either with or without a need for long-term care. The Department expects, however, that it will be possible to identify performance benchmarks after additional data from Family Care and from other programs are accumulated to provide a basis for comparison. Second, as we gain experience with this outcome-measurement process, we are making small process adjustments between rounds of interviews. Although this improves the reliability of the results for each successive round of measurement, it limits the extent to which we can, at this time, establish benchmarks or compare the results from one round of measurement to another.

The primary value of this baseline information lies in the guidance it provides to quality improvement efforts. Results of the first round of member-outcome interviews provided the Department and the CMOs with detailed, reliable information with which to identify

directions for quality improvement efforts. For example, after the first round of member-outcome interviews was completed, the Fond du Lac County CMO was concerned with the level of member outcomes found to be present for members with developmental disabilities in "People choose where and with whom they live." CMO staff then focused on identifying members' outcomes and additional efforts that could support that outcome for more people. Over the next year, the CMO worked on reducing the size of several residential facilities to provide more private rooms and alternate living situations for members who requested a change. As a result of the efforts of the CMO, the percentage of interviewees with developmental disabilities for whom this outcome was present doubled between the first round to the second round of member-outcome interviews.

In December 2001, CMOs were provided with the detailed results of the member-outcome interviews for their members, and each CMO discussed these results with the Department. Staff of some CMOs have indicated plans to use the interview results from the second round of member-outcome interviews to assess the level of outcomes and supports for members using self-directed supports, to discuss quality with supported-employment providers, to analyze outcomes by service provider, and to inform staff, governing boards, and various committees and councils. The Department is conducting program-level analyses of the results and the process and will include results by CMO and by target group in an upcoming report.

More importantly, we hope that focusing on member outcomes will promote consistent attention at all levels to our ultimate purpose: improving the quality of life for people who need the services. At the local level, outcomes-focused care managers and providers will listen to the individuals who receive the services and find flexible, creative ways to provide support for their desired outcomes. At the Department level, outcome-focused staff will find ways to identify and share best practices among local programs to assist them in meeting equally high levels of performance. Outcome-focused state and federal policy makers will be able to direct resources to the most cost-effective programs.

Introduction

When the Department of Health and Family Services joined with consumers, advocates, and providers to redesign Wisconsin's system of long-term care for elderly people and people with physical and developmental disabilities, it was recognized that the quality assurance methods would need to be as advanced and innovative as the system itself, now known as Family Care.

The Department's Center for Delivery Systems Development convened the "Designing Quality Work Group" in December 1997. This work group included consumers, providers, advocates, and staff of the Department's Bureau of Developmental Disability Services (BDDS), Bureau on Aging and Long-Term Care Resources (BALTCR), and the Division of Health Care Financing. The group established three core elements of a consumer-centered approach to quality assurance. First, the system was to be based upon outcomes relating to the consumers' health and quality of life rather than on the attributes of the services. Second, the quality assurance system was to incorporate objective assessment of whether these outcomes were present for each individual enrolled in Family Care; and finally, it was to provide for system improvement based on these objective assessments.

The Department incorporated the 14 consumer outcomes identified by the Designing Quality Work Group into the Family Care statutes, administrative code, and standard contracts to be used with organizations that serve Family Care members. Under the terms of these requirements, CMOs began operation in Fond du Lac County in February 2000, La Crosse and Portage Counties in April 2000, and Milwaukee County in July 2000, and in Richland County in January 2001.

Outcomes place the focus on consumers' quality of life rather than on processes.

Traditionally, expectations for quality in human services have been expressed in terms of the service providers' compliance with prescribed standards, such as the frequency of contact with the consumer, hours of personal care, and the professional qualifications of service providers. While the Department has consistently sought to purchase only quality services, we need to address a critical question: if a connection between a program's services and individual outcomes that are desired by the consumer cannot be demonstrated, is it cost-effective to purchase that service or to fund that program?

The work group refined a list of 14 Family Care outcomes, shown on the following page. These outcomes are:

- Global, applying to all people, seniors and non-seniors, people with or without disabilities, and people who are ill or well;
- Holistic, covering the quality-of-life aspects of community integration, self-determination, and choice, as well as health and safety; and
- Designed to take into account each individual's attitudes, beliefs, culture, behaviors and environmental circumstances.

Family Care Member Personal Outcomes

Detailed explanations of each of these outcomes can be found on page 6.

Self-determination and choice outcomes

1. People are treated fairly.
2. People have privacy.
3. People have personal dignity and respect.
4. People choose their services.
5. People choose their daily routine.
6. People achieve their employment objectives.
7. People are satisfied with services.

Community Integration outcomes

8. People choose where and with whom they live.
9. People participate in the life of the community.
10. People remain connected to informal support networks.

Health and Safety outcomes

11. People are free from abuse and neglect.
12. People have the best possible health.
13. People are safe.
14. People experience continuity and security.

Each person defines the circumstances that achieve the outcome for his or her own life. For example, one person might want to live alone, while another might prefer to live in a congregate setting. Different services are needed to achieve the same outcome—having a choice about where and with whom to live—for both. This approach to quality is based on a belief that consumers, not providers, should determine what results they want and need from services and supports.

Definitions of Outcomes

Definitions are adapted from the Council on Quality and Leadership's *Personal Outcomes Measures 2000 Edition* manual.

Outcome	Outcome Definition
People are treated fairly.	Each person is guaranteed the opportunity to be heard and treated fairly as an individual in any situation where limitations are imposed. Limitations may occur as the result of laws, community or group norms, or the needs of other people, but should be temporary. People have the right to expect that they will be informed of options, give consent to proposed actions, have their personal concerns be considered important, and have a fair and impartial hearing in disputes.
People have privacy.	Privacy is freedom from unwanted intrusion; each person has different requirements for privacy. People may need private space and time when talking on the telephone, reading mail, and being with friends, family, and others. When people live together, privacy is more complicated; it may not be possible for each person to have access to privacy at the same time. Privacy is particularly important when staff assist and support people with personal hygiene and health needs. Dignity and respect must always be demonstrated, and people should decide who provides this care.
People have personal dignity and respect.	Respect indicates that we believe that someone is a valued person. Respect is more than the absence of negative comments or actions. Respectful treatment and interactions enhance the person's self-esteem and result in positive perceptions by others. Respect is demonstrated by how people interact. Respect means listening and responding to the person's needs with the same promptness and urgency that anyone would expect.
People choose their services.	Services exist to help people get what they want and need. The ability to choose where to shop, do business, or obtain services means that people are more likely to get what they want and need. Choice means offering options for services and interventions and respecting members' wishes. A person's ability to choose and make decisions regarding services changes throughout his or her life.
People choose their daily routines.	Being able to make choices about daily activities is basic to exercising personal control. People need to be able to make choices in organizing their personal routine of activities to express their individuality. Routine activities include choosing times for work, leisure, personal care, eating, and sleeping; making menu choices; selecting clothes for the day; and setting aside time to spend with family and friends.
People achieve their employment objectives.	Finding and choosing a job and a career is an important life decision. People can have productive lives with or without paid employment, if they have meaningful activities that provide similar social and personal rewards. People should have the opportunity to consider a range of choices such as paid employment, volunteering, continued learning, or leisure activities.

Outcome	Outcome Definition
People are satisfied with services.	Satisfaction as defined by the person is a key to quality of services and supports. Satisfaction is related to what people think of services and supports, what their expectations are, and what else they want for the future. Satisfaction does not necessarily mean getting everything you want, but it is more likely to occur when people feel that they are seen as important and treated with respect. The absence of a complaint does not mean the member is satisfied.
People choose where and with whom to live.	Choice of a living situation is important in all people's lives. People should be able to choose their living arrangement, location, and the person with whom they live if they prefer to live with others. People need opportunities to see what is available and to make informed choices.
People participate in the life of the community.	The community has many resources for personal support, enjoyment, and personal development. When people go out in the community they meet other people, learn, and broaden their experiences. Generic community resources, such as doctors, restaurants, banks, grocery and retail stores, should be the preferred choice for health, leisure, and routine daily living activities.
People remain connected to informal support networks.	Informal support networks are groups of people, such as family and close friends, whose support of each other is usually lifelong and results in security and the provision of a safety net to the person. Informal support cannot be created or manufactured, but can be nurtured as people and relationships grow and evolve. Time, age, and distance can affect how well people remain connected.
People are free from abuse and neglect.	Treating people with dignity and respect requires that they are free from abuse and neglect. Actions and practices that may constitute abuse and neglect need to be functionally defined and understood. Abuse is defined and measured according to the person's experience, regardless of when it occurred.
People have the best possible health.	Best possible health must be defined in terms that are satisfactory to the member. The definition of "best possible health" depends on the current health status of the member and the possibility of health interventions to restore lost capacity, provide stabilization or minimize further loss of function. Health care interventions should be personalized and effective. Frail elderly people and people with disabilities should have access to health care services of the same variety and quality available to others.
People are safe.	Each of us needs to feel safe from danger in our homes, workplaces, neighborhoods, and communities. People rely on regulations and inspections to ensure standards are met in certain settings to ensure safety, and they rely on personal actions (such as installing smoke detectors or security alarm systems) to feel safe in other settings. However, normal environments contain a reasonable amount of risk, and overprotection can prevent people from leading a fulfilling life.
People experience continuity and security.	Change can contribute to happiness or discontent. Understanding and recognizing the emotional impact of change on a member is vital to providing consumer-centered services and supports. Economic security plays a significant role in enabling members to plan for the future. People should be included in all relevant decisions that impact their lives.

The link between outcomes and services is made by asking two separate questions:

- Is each outcome present for each person as he or she defines it?
- Is the organization providing supports and services to promote achievement of those outcomes?

All desired outcomes cannot be expected to be present at any given time, either for people with or people without disabilities. However, the professionals who assist the individual in obtaining needed services should be aware of the consumer's preferences and take them into account when planning services and supports. At the center of a client-centered system is the need for care managers and providers to listen to and learn from each person, identify the values and preferences that define his or her desired outcomes, and incorporate these into the individual's service plans.

For example, if a person who lives in a congregate setting prefers to live alone, the outcome "choose where and with whom to live" is not present. However, if the individual's care plan includes both services to help the individual learn the skills necessary to live alone and a process to develop an independent living situation, the supports are being provided to help achieve the outcome.

If the person who lives in the congregate setting is aware of available choices and truly does prefer to live there, the outcome, "choose where and with whom to live" is present. However, the person's care manager may never have talked to the person about his or her options or desires for a living situation. In that case, supports for the outcome are not being provided.

Consumer outcomes are objectively assessed.

To develop these assessment methods, the Department drew upon methodology developed by the Council on Quality and Leadership (the Council), a nationally recognized authority for the accreditation of long-term care programs for people with disabilities. For more than ten years, the Council has been refining interview and information-collection methods that enable trained interviewers to determine whether consumer outcomes are present and whether outcome-based supports are provided. These methods incorporate interviewing techniques that vary depending upon the verbal skills of the consumers. Interviewers use decision-making guidelines to determine a person's personal preferences for social and support networks, lifestyles and role functions, activities, and other factors related to outcomes, and whether those outcomes are present in the person's life. The process also incorporates methods for ensuring that all interviewers are using the process the same way ("inter-rater reliability").

Although the Council's experience has been mostly with people with disabilities, rather than with elderly people, the Department has been working with the Council to adapt the assessment techniques to the needs of elderly consumers. In particular, BALTCR staff have been, and continue to be, helpful in refining the interview questions and techniques for use with elderly individuals. For example, the outcome, "People achieve their employment objectives" was framed for elderly individuals to assess whether they had meaningful and fulfilling daytime activities. Planning is currently underway to develop a separate set of

outcomes for elderly individuals. These outcomes and the techniques to be used to measure them will be developed with the assistance of focus groups consisting of elderly individuals, family members and advocates, and care providers and other professionals. The set of outcomes that results from this process may differ from the 14 outcomes developed by the earlier workgroup.

The Department assessed the presence of the outcomes by gathering information directly from a randomly selected sample of Family Care members in face-to-face conversations. Interviewers also contacted the lead professional of each member's care management team. Using decision-making guidelines similar to those used for the member interviews, the interviewer determined whether outcome-based support was being provided to the member. If the care manager was familiar with the person's needs and preferences and had taken steps to promote the achievement of the outcomes as desired by that individual, the interviewer determined that support had been provided to achieve member-defined outcomes.

Assessment of outcomes and supports provides a basis for system improvement.

Traditional methods of monitoring quality focus on compliance with standard procedures and organizational processes, and emphasize documentation of compliance with regulations. These traditional systems typically depend upon the judgment of professional inspectors. The result is the identification of deficiencies leading to required plans of correction, and administrative sanctions that may involve threats of loss of funds or fines.

In contrast, focus on assessing consumer outcomes will better enable providers to know and understand their clients as people with goals similar to their own and will provide an incentive to adapt services more creatively to the needs of each unique individual. No longer will it be acceptable to provide services that do no more than meet minimum licensure standards; providers will be expected to support the achievement of desired results for the individuals. Knowledge about outcomes enables consumers and their families to reject services that are ineffective, and allows policy makers to redirect resources to programs that do a better job of improving the health and well-being of their consumers.

At the local level, each care management organization (CMO) is required to have an internal quality assessment and improvement program that collects and reports information on desired member outcome measures, identifies people who do not achieve desired outcomes, and allows the CMO continuously to monitor and evaluate its own performance and that of its providers.

At the state level, Family Care outcomes are measured periodically by selecting a sample of CMO members, interviewing them and their lead care managers, and analyzing the compiled results. The first series of these assessments, which established baseline measures of outcomes and supports, was carried out between November 2000 and January 2001. The second series was carried out between May and November 2001. Results of the second round of interviews are included in this report.

The results are not to be considered a numeric report card, and no minimum required levels for outcomes and supports have been identified. Instead, collaborative examination of this information will enable the Department and the CMOs to identify and learn from areas of strength, and to identify areas needing improvement. Although we cannot expect all outcomes, or even any single outcome, to be present for all consumers, experience with these measures will, over time, provide a basis for reasonable expectations and comparisons. Most importantly, comparison of results over time will enable the Department, CMOs, consumers, and others to determine whether improvement is taking place.

Additional methods help to assure Family Care quality.

Measuring consumer outcomes is only one component of the comprehensive quality assurance and quality improvement strategy for Family Care. A variety of approaches are being used to ensure the quality, efficiency, and accountability of the care management organizations.

The Department evaluated each local organization before its certification as a Family Care CMO and re-certifies each CMO annually. Each CMO must demonstrate:

1) Expertise in determining and meeting the needs of its target population, including a sufficient number of qualified and knowledgeable care managers and linkages with primary and acute health care services;

2) Adequate availability of qualified providers with the expertise and ability to serve the CMO's target population in a timely manner; and

3) Organizational capacity to operate as a CMO, including financial solvency and stability, and ability to collect and analyze data for financial management, quality assurance, and quality improvement.

After the CMO has begun operations, the Department conducts periodic quality-assurance site visits. Each CMO received a site review six months after it began operations, and now receives annual site reviews. These site reviews include such issues as quality improvement, access, adequacy of provider network, choice, quality of life of members, safety and the system in place to ensure safety and the degree to which Family Care outcomes are being pursued.

In addition, the Department conducts quarterly reviews of individual service plans to ensure each CMO's performance in identifying and planning for the service needs, individual preferences, and desired outcomes of its members.

The Department also monitors each CMO's performance through self-reported performance measures tied to the Family Care outcomes, and results of outcome-focused performance improvement projects each CMO has conducted during the contract year. The Department reviews required reports that are submitted by the CMOs, including logs of complaints and grievances and quarterly narrative reports.

The Department also reviews contract compliance by the CMOs; cost-effectiveness of the Family Care program; and the compliance and performance of the resource centers, another component of the Family Care program. Finally, an independent external evaluation of Family Care is being conducted by the Lewin Group, a private research firm, under contract with the Wisconsin Legislative Audit Bureau.

The Family Care Outcomes in 2001

Preparing for and conducting the assessments

The Department began working in July 2000 with the Council to develop a detailed strategy and workplan for assessing outcomes and supports for the members of the new CMOs. Critical elements for carrying out a reliable assessment of outcomes and supports included:

- **Devising the interview tool**. Focus groups including staff from the Department's BDDS and BALTCR reviewed the Council's interviewing tool and, in consultation with the Council, added questions for each outcome that were pertinent for each target group. The final Member Outcome Interview Tool, included in Appendix I, was used by the interviewers to guide their conversations with CMO members and elicit the information necessary to determine whether the outcomes were present for each member.

- **Training and testing the interviewers**. Staff from BDDS and The Management Group, which works under contract with BALTCR, are trained in the Council's outcome-assessment techniques for elderly people and people with disabilities. After their training, each interviewer is tested to ensure that inter-rater reliability (an indicator of the probability that any two interviewers would reach the same judgment in a given situation) reaches at least 85 percent. Periodic re-testing occurs throughout the year to ensure the interviewers maintain inter-rater reliability.

- **Selecting a random sample**. A random sample of CMO members is drawn, to contain a sufficient number of individuals in each Family Care target groups to allow valid results for each, and for the program as a whole.

- **Arranging the meetings with consumers**. The selected individuals, or their guardians if appropriate, were contacted to request their participation. Individuals may decline to participate; in the past, reasons included, "attending college," "not enough time," "everything is going well," or medical reasons. For those who accept, arrangements are made to carry out the conversation at a time and location of their choice, with any additional arrangements for special communication needs.

For the second round of interviews, a sample of 669 individuals was randomly selected from Family Care's April 2001 membership of 2,571. Between May and November 2001, 492 of these members were interviewed about their individual preferences related to the 14 Family Care member outcomes. After interviewing both the CMO member and his or her lead care manager, interviewers reached two determinations for each outcome: 1) was the outcome present in the member's life, and 2) was the CMO providing support for the achievement or maintenance of that outcome as defined by the member? A more detailed description of the methodology is included in Appendix I.

Outcomes indicate quality of life; supports indicate quality of service.

For each outcome, two results are reported: the percent of interviewed members who reported that the outcome was present (quality of life), and the percentage of members for whom support for that outcome was found to have been provided by the CMO (quality of service).

Although each outcome has a general content area, interviewers established whether the outcome was present as defined by each individual's own preferences. For example, the outcome "People have privacy" has certain universal meanings, such as freedom from unwanted intrusions and dignity when being assisted with personal hygiene. However, some people like to be alone more often than others.

Supports were judged to be present if the lead care manager could demonstrate both that:

- The individual's preferred outcomes were known to the care management team, and
- Staff of the CMO were planning or carrying out actions that would achieve or maintain the outcome as defined by the individual.

Supports were considered to be provided only if the actions or services were designed around the outcomes as defined by the member, rather than being pre-defined standards or expectations that did not reflect the desired outcomes of the person being served. Although many additional members are receiving services and support in these areas that is considered to be appropriate for the consumers' needs by others, these results indicate only how many were receiving services and support tailored to their personal preferences.

For each individual, there are four possible combinations of outcomes and supports, shown below.

		Quality of Service	
		Support Present	Support not present
Quality of Life	Outcome Present	+ +	+ –
	Outcome not present	– +	– –

If both the outcome and the support are present (+ +), the person has defined his or her desired outcome and has found a way to achieve it. In addition, the CMO professionals are aware of the person's desires and are assisting the person to achieve them. It will be important that supports remain in place for the member so that any change in the member's needs or preferences will be reflected in the member's care plan.

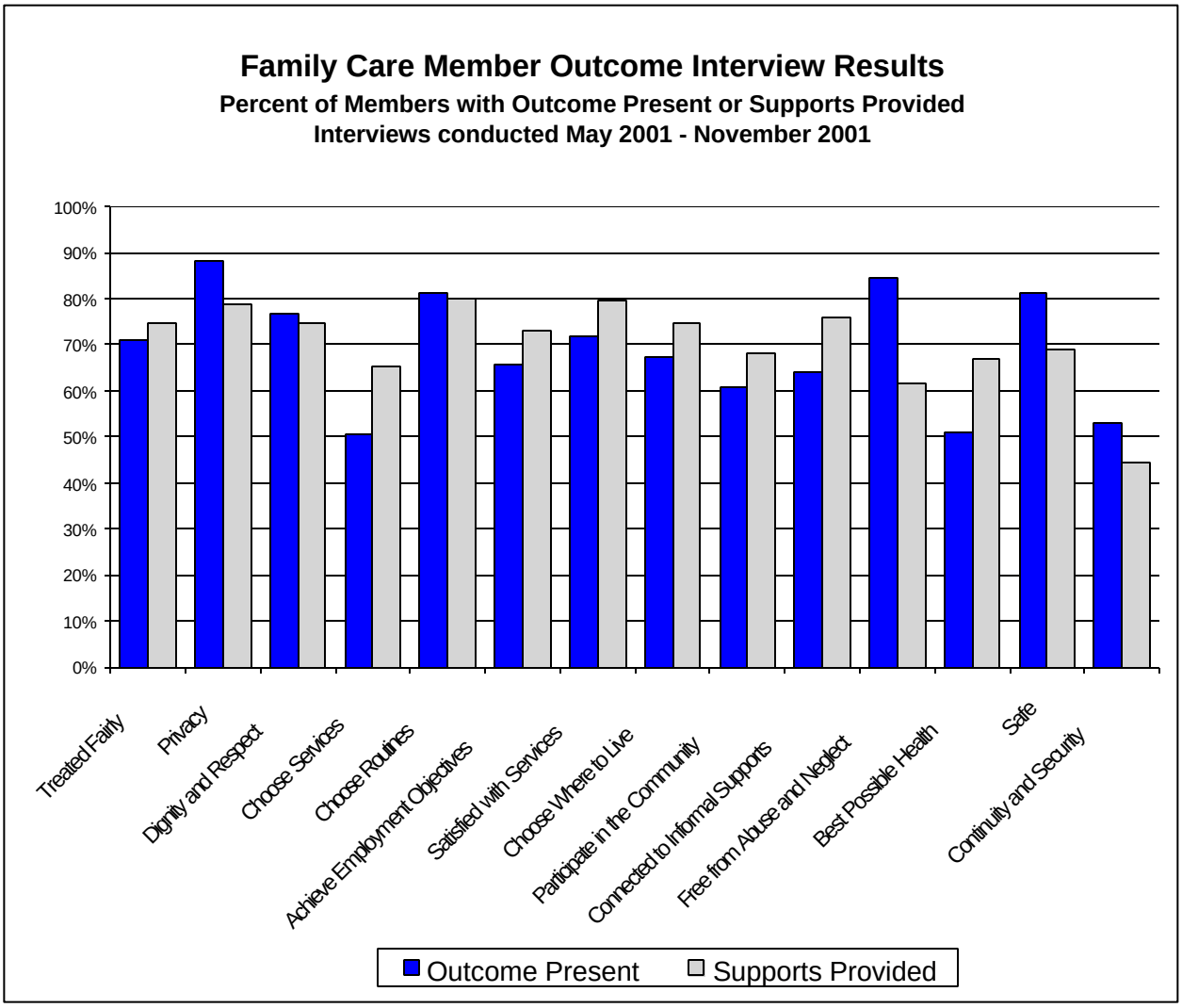
If the outcome is not present, but the support is (– +), the person's desired outcome has been identified and the CMO professionals are working to support it. However, a variety of circumstances may be preventing the achievement of the outcome. The person's capabilities

might not yet be developed to the point where he or she can obtain the desired outcome, such as when a person is in training for paid employment, or scheduled services or placements may be arranged but not yet implemented, such as when a person is on a waiting list for specialized housing. In other cases, members may express desires for outcomes that are not attainable, such as desiring no support from family or friends other than being reunited with a deceased spouse. In this case, the member's desired outcome will never be present, but the care management team can provide support to help the member with grief and with coping skills.

If the outcome is present, but the support is not (+ −), the person has defined his or her desired outcome and has found a way to achieve it. However, the CMO professionals who are responsible for the person's plan of care may not be aware of the person's desires and may therefore be providing services that, while considered appropriate by others, may not be the most effective way to ensure the member's quality of life. It will be necessary for the care management team to become more responsive to the needs and preferences of the person—even in the absence of any expressed concerns or complaints by the individual—to ensure that the member's outcome remains present over time.

If the neither the outcome nor the support are present (− −), the person may have preferences regarding the outcome but may not yet have found a way to achieve it. The person may not even be aware that his or her desires in the area are relevant to his or her care. In addition, the CMO professionals have not yet been responsive to the needs and preferences of the person, either because they are not aware of the person's needs and preferences or because they have not yet incorporated them into planning for the person's care.

The figure on the next page shows the results for each of the 14 outcomes across all five CMOs. For each outcome measurement, there are two bars. The first, darker bar indicates the percentage of members for whom the outcome was present; the second, striped bar indicates the percentage of members for whom the CMO has in place a process to support the member's desired outcome.



Not surprisingly, we found a high correlation between the presence of supports and the presence of outcomes. Nevertheless, in 8 of the 14 outcomes, levels of support provided were higher than the levels at which outcomes were achieved. For example, supports for "People have the best possible health" were present for 66.7 percent of the members, although only 50.8 had that outcome present; 72.9 percent had supports for achieving their employment objectives, although only 65.8 had achieved the outcome; and 79.4 percent were receiving support for being satisfied with their services, although only 71.8 percent had this outcome present. Because of the high correlation between having supports present and attaining the outcome, it is reasonable to expect that in many of these cases, additional time is needed to attain the outcome, after it is identified and supports have been put into place.

For the remaining six outcomes, the proportion of members for whom the outcome was present is greater than the proportion who were receiving support for the outcome. In these cases, a member may have achieved the outcome on his or her own, may be receiving

support from some source unknown to the member's care management team, or may be receiving services from the CMO that do not reflect the member's preferences. Nevertheless, it is important for the care management team to be aware of the member's preferences and concerns and to monitor his or her level of satisfaction over time.

In the most dramatic example, individual outcomes for "People are free from abuse and neglect" were present for 84.3 percent of the members interviewed, while only 61.4 percent have received support from the CMO for the outcome. This indicates that in some cases, CMO staff may be relying on their contracted providers' organizational safeguards against abuse and neglect without seeking to determine whether each member feels protected by these safeguards. Care management teams need more consistently to seek information about members' concerns with abuse and neglect—even in the absence of complaints—to ensure that the outcomes remain present over time.

It should be noted that interviewers had been instructed, if they noticed immediate health or safety problems during their conversations with members, to ensure the safety of the member by taking any immediate action necessary to protect the member and to bring the problem promptly to the care manager's attention. Each CMO has been provided with the information from its members' interviews, so that the CMO can attend to any less immediate but unaddressed concerns about abuse and neglect among their members.

Although we do not yet know the attainment levels that can realistically be achieved for each of these outcomes (and they will differ by outcome), this information indicates that members' quality of life can be improved in several outcome areas. An example of how results might change is evident in the results for "People choose their services." The first, or baseline, round of Family Care member outcome interviews indicated that only 42.9 percent of Family Care members had achieved that outcome and that only 42.8 percent of the members were receiving support for their personal outcomes. This finding drew immediate attention from the Department and from CMOs because the design of the Family Care program places significant emphasis on responsiveness to individuals' needs and desires. As a result of CMO attention to this outcome, the percentage of members receiving support for this outcome rose to 65.3 percent in the second round, while the percentage attaining their outcome rose to 50.4 percent in the same amount of time. It remained the outcome with the lowest level of outcomes present, so continued effort is necessary.

Results for Outcome
"People Choose their Services"

	Baseline	2001
Outcome present	42.9	50.4
Support present	42.8	65.3

Results for Each Outcome

Self-Determination and Choice Outcomes

1. People are treated fairly.

Each person is guaranteed the opportunity to be heard and treated fairly as an individual in any situation where limitations are imposed. Limitations may occur as the result of laws, community or group norms, or the needs of other people, but should be temporary. People have the right to expect that they will be informed of options, give consent to proposed actions, have their personal concerns be considered important, and have a fair and impartial hearing in disputes.

The outcome *is* present if:

- No rights limitations or fair treatment issues have been identified by the member; *or*
- Due process was provided to the member if there were rights limitations or fair treatment issues.

The outcome *is not* present if:

- Limitations have been imposed on the member, but the member has not agreed to the limitations, does not know why they were imposed, is unaware of any plan to change the limitation, or if due process to have the limitation lifted has not been provided; *or*
- The member is unaware of how to file a complaint if he or she experienced unfair treatment.

To support these outcomes, CMO staff should be aware of any rights restrictions or limitations imposed upon a member. They should provide members with training and support so that limitations are reversed or removed. The care manager should provide the members with access to a fair and impartial hearing of grievances and an independent review of limitations to personal freedoms. The CMO should review and change policy and practice that limit or restrict members.

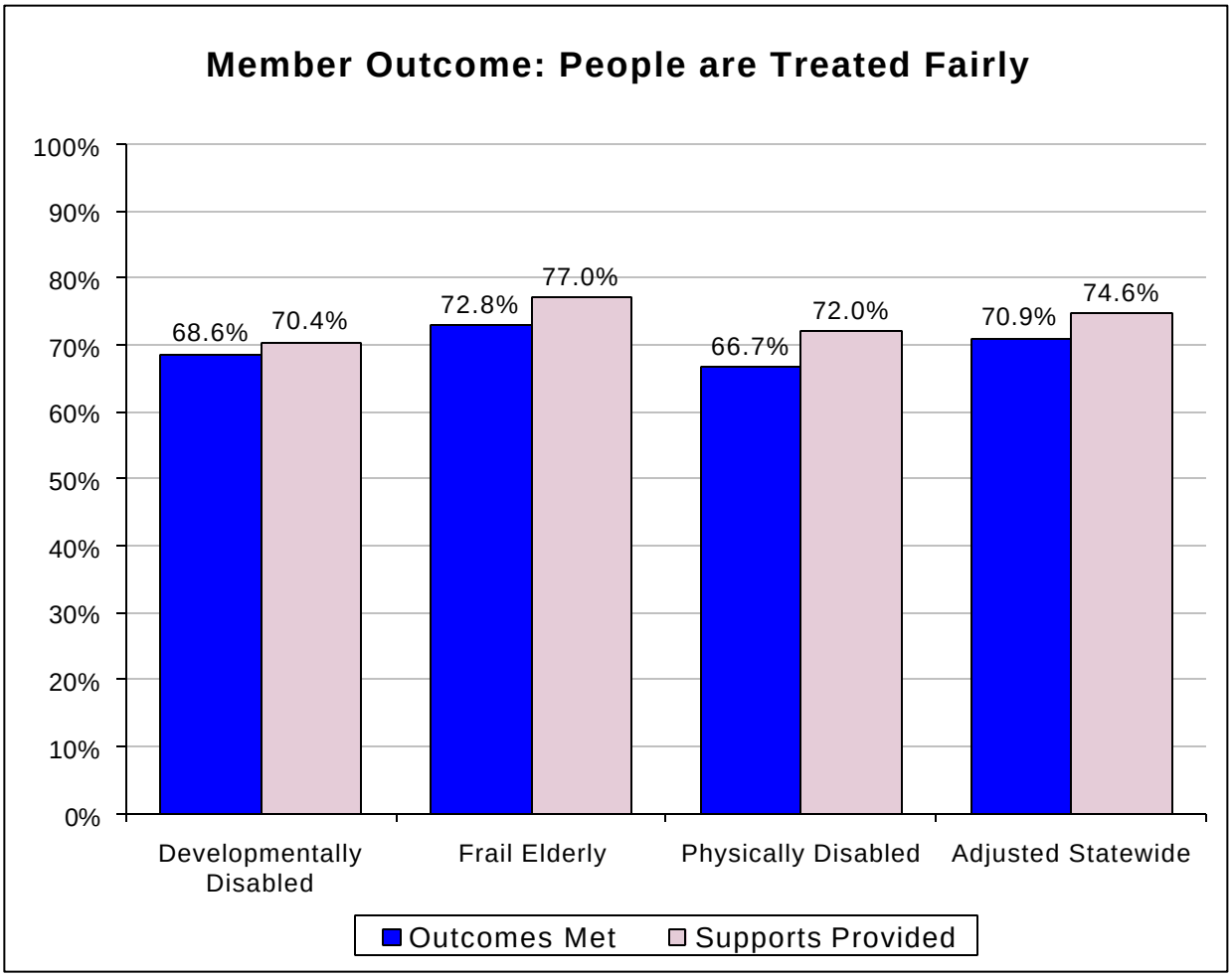
The support *is* present if:

- The care manager solicited information about rights violations or fair treatment issues from the member; *and*
- The care manager has implemented procedures for addressing the person's concerns.

The support *is not* present if:

- The CMO is not providing due process when limitations are imposed;
- The care manager is not aware of existing rights violations;
- There is no plan in place to remove existing restrictions; *or*
- The care manager has not asked the member about fair treatment.

This outcome was achieved for 70.9 percent of the interviewed members. However, supports were found to be present for the personal outcomes of 74.6 percent of the members, Results did not vary significantly among the target groups in the 2001 measurement, although supports had been lower for individuals with developmental disabilities in the baseline measurement. For this group, the rates of supports present increased from 46.8 percent in the baseline to 70.4 percent in the 2001 measurement.



2. People have privacy.

Privacy is freedom from unwanted intrusion; each person has different requirements for privacy. People may need private space and time when talking on the telephone, reading mail, and being with friends, family, and others. When people live together, privacy is more complicated; it may not be possible for each person to have access to privacy at the same time. Privacy is particularly important when staff assist and support people with personal hygiene and health needs. Dignity and respect must always be demonstrated, and people should decide who provides this care.

The outcome *is* present if:

- The member has time during the day for private activities and general privacy;
- The member can go somewhere to be alone or with friends;
- Privacy is provided when the member desires or requests it; *and*
- The person is satisfied with the level of privacy offered.

The outcome *is not* present if:

- The member is not provided privacy when requested;
- The member's behavior during personal time is not private;
- The member does not have space to be alone; *or*
- Personal hygiene or health needs activities are not conducted in a way to ensure dignity and respect.

To support these outcomes, the care manager should be aware of the member's need for privacy and his or her preferences regarding privacy. The care manager should ensure that the member has opportunities for privacy, particularly in settings where many people live together. The care manager should ensure that staff assignments to assist a person with personal hygiene reflect personal preference and sensitivity to the dignity of the person.

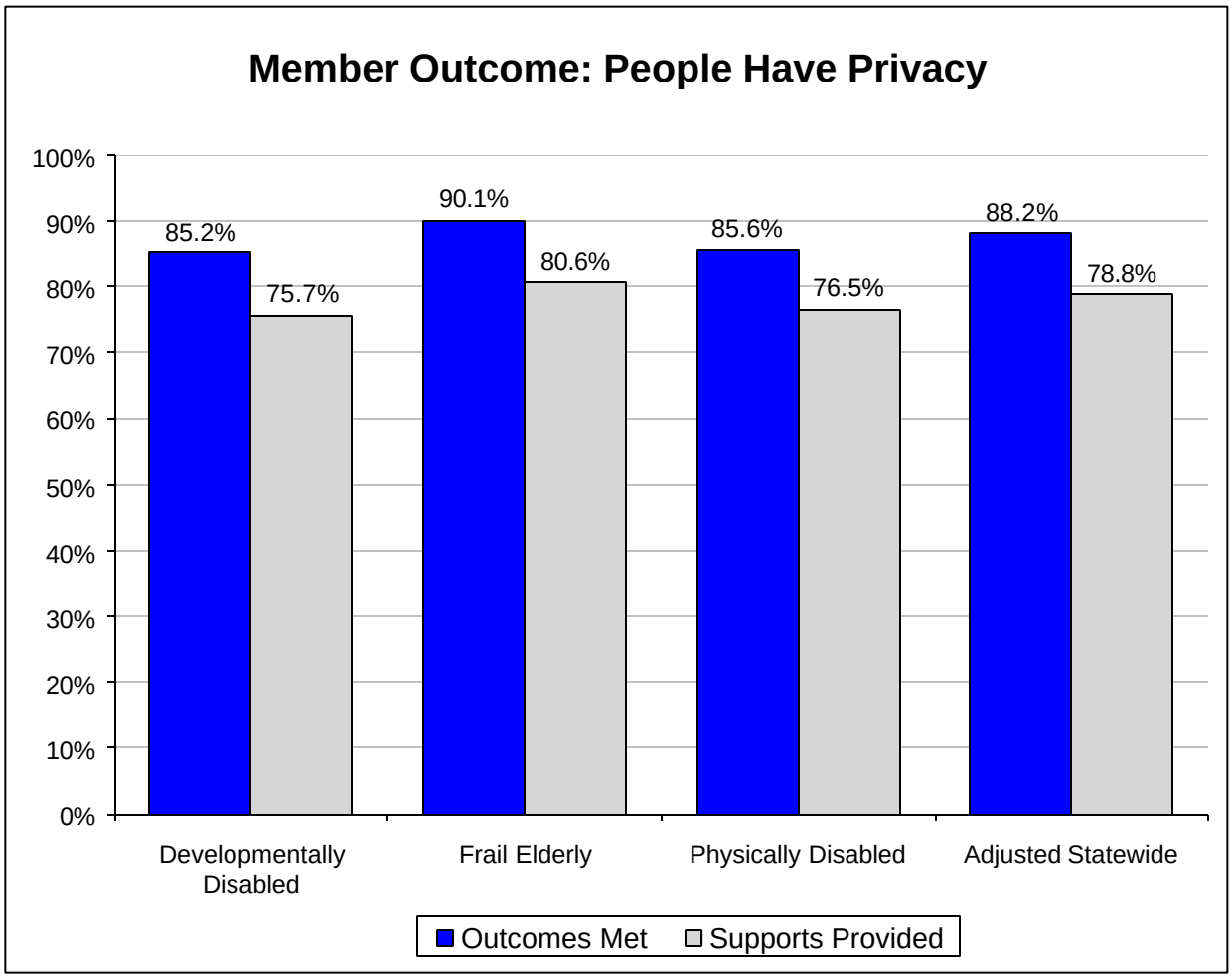
The support *is* present if:

- The care manager knows the member's preferences for privacy or is making efforts to learn about preferences; *and*
- If the accommodations are made to honor the member's preferences.

The support *is not* present if:

- The care manager is not knowledgeable about the member's preferences regarding privacy and is making no efforts to learn about them;
- The care manager does not have a plan to accommodate the member's preferences; *or*
- The care manager is not aware of the provider's procedure during personal hygiene activities.

Individual outcomes for privacy were present for a larger proportion of members (88.2 percent) than for any other outcome, and represented the most-frequently achieved outcome among each of the three target groups. The 90.1 percent result for elderly individuals was the highest level reported for any outcome by any target group.



3. Personal dignity and respect

Respect indicates that we believe that someone is a valued person. Respect is more than the absence of negative comments or actions. Respectful treatment and interactions enhance the person's self-esteem and result in positive perceptions by others. Respect is demonstrated by how people interact. Respect means listening and responding to the person's needs with the same promptness and urgency that anyone would expect.

The outcome *is* present if:

- The member reports feeling respected by others; *and*
- Interactions between the member and others reflect concern for the member's opinions, feelings, and preferences.

The outcome *is not* present if:

- Others are not calling the member by his or her preferred name;
- The member does not feel that his or her opinions are valued or that others are listening; *or*
- The member does not feel challenged in daily activities or encouraged to try new things.

An isolated example of disrespectful interactions or practices would not automatically cause the outcome to be considered not present.

To support these outcomes, the care manager should be aware of the member's preferred name, and use it with respect for the person. Confidentiality should be exercised when speaking about the member. The opinions and preferences of the member should be included in the planning and decision making processes. The care manager should also display concern about the member's feelings and avoid anything that may cause the member any personal, physical or social discomfort.

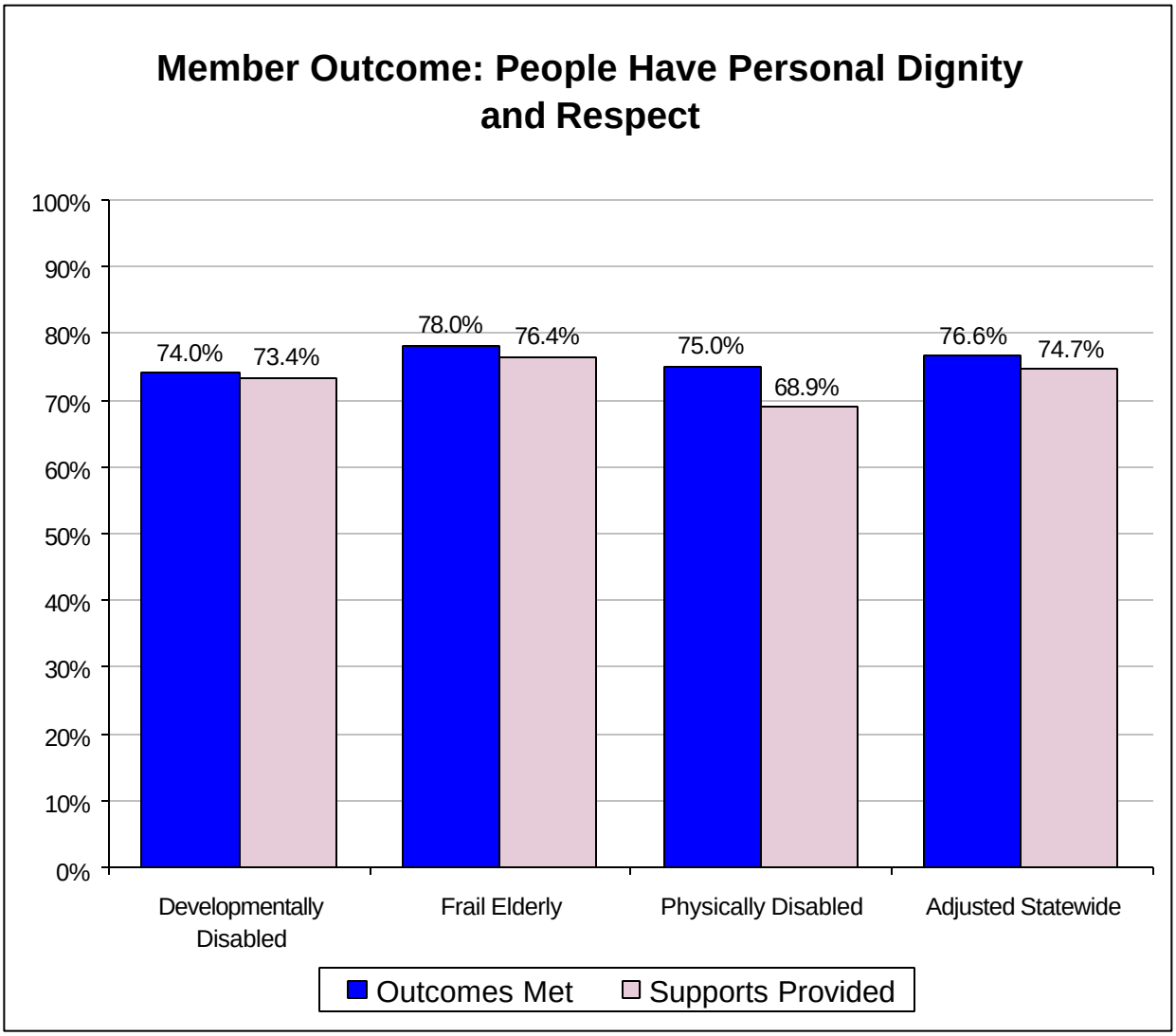
The support *is* present if:

- The care manager knows what is important to the member with regards to respect;
- The care manager takes action to ensure the interactions with the member are respectful; *and*
- Supports needed to enhance the member's self-image have been identified and implemented.

The support *is not* present if:

- The care manager does not know whether the member feels respected and is not knowledgeable about the member's preferences regarding respect;
- The care manager does not have a plan to assist the member when he or she feels disrespected; *or*
- The care manager has not discussed respect with the member.

The proportion of members for whom this outcome was present (76.6 percent) and for whom supports were provided (74.7 percent) were relatively high for this outcome compared to other outcomes, and levels of outcome and support were relatively close for each target group.



4. People choose their services.

Services exist to help people get what they want and need. The ability to choose where to shop, do business, or obtain services means that people are more likely to get what they want and need. Choice means offering options for services and interventions and respecting members' wishes. A person's ability to choose and make decisions regarding services changes throughout his or her life.

The outcome *is* present if:

- The member has choices about service providers;
- The member selected the services or supports that he or she receives; *and*
- The services or supports focus on the member's goals.

If the member did not originally choose his or her services, but has decided to maintain the current services after options have been presented, the outcome is present.

The outcome *is not* present if:

- The member has not been presented options of services;
- Has not been consulted when decisions were made regarding services; *or*
- Is not aware that he or she can change services.

To support these outcomes, the care manager should be aware of the member's preferences for services and provide choice of providers. The care manager should assist the member in gathering information, should discuss benefits and drawbacks of different services, and should visit the service setting and meet the employees. The care manager should not arrange services that do not match the member's preference. Options may be limited, but not because the care manager believes that the option may not be a good match for the member. The care manager should identify what decisions the member is able to make and should provide support to support or expand decision-making capability over time.

The support *is* present if:

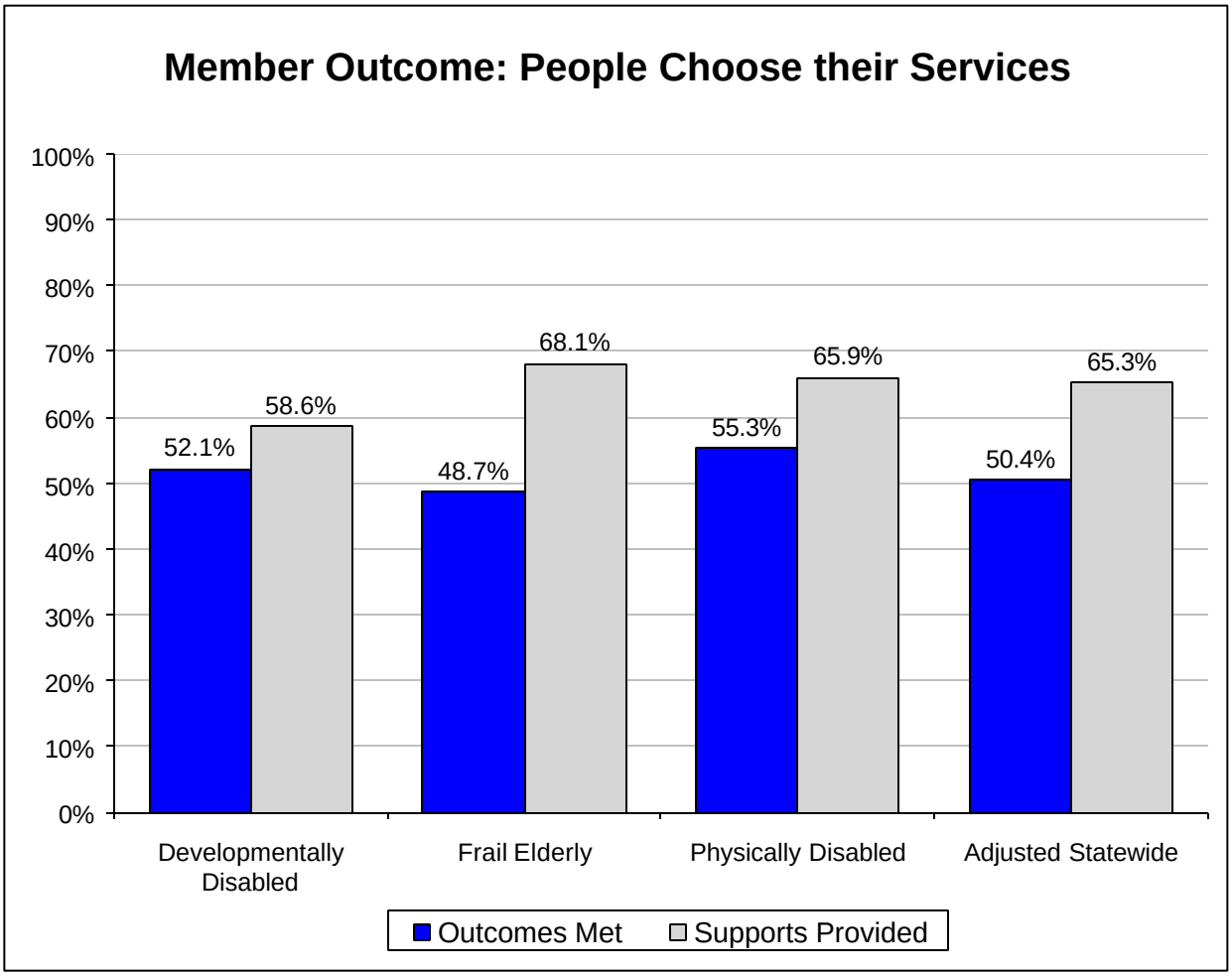
- The care manager actively solicits the member's preferences for services and providers;
- The care manager provides options to the member about services and providers; *and*
- The member's choices about services and providers are honored.

The support *is not* present if:

- The care manager is not knowledgeable about the member's preferences;
- Service options have not been presented to the member;
- The care manager has not discussed choice of service with the member; *or*
- No plan is in place to address the member's preferences.

As noted, results for this outcome improved over the baseline measure, when outcomes were found to be present for 42.9 of the members. The rate at which the supports were present for individuals with developmental disabilities and the frail elderly increased over the baseline results, most notably for individuals with developmental disabilities, for whom the supports result almost doubled. Still, this outcome was present for a smaller proportion of the interviewed members (50.4 percent) than any of the 14 outcomes.

Curiously, a notably larger proportion of members (71.8 percent) reported that their personal outcomes were present for a related outcome – 'People are satisfied with their services.' The Department and the CMOs will need to examine the reasons for the lower levels of supports found to be present for individuals with developmental disabilities, in comparison to the other two target groups.



5. People choose their daily routine.

Being able to make choices about daily activities is basic to exercising personal control. People need to be able to make choices in organizing their personal routine of activities to express their individuality. Routine activities include choosing times for work, leisure, personal care, eating, and sleeping; making menu choices; selecting clothes for the day; and setting aside time to spend with family and friends.

The outcome *is* present if:
- The member had choice about what to do during the day; *and*
- The member chose when, where and for how long he or she would engage in routine activities such as household chores, meals, bathing, rest, recreation, and leisure activities.

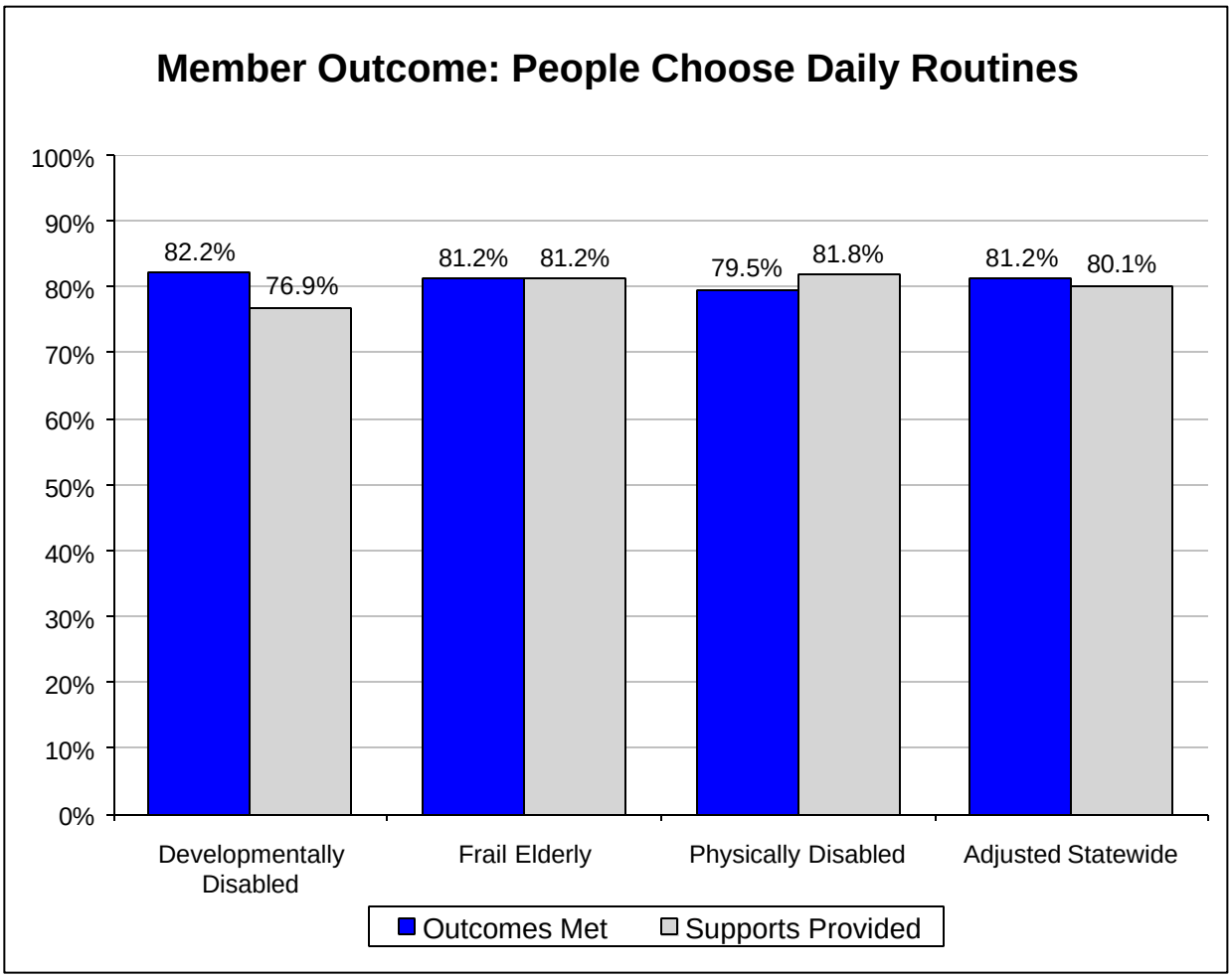
The outcome *is not* present if:
- The member has not been provided with opportunities to make choices;
- Options have not have been presented to the member; *or*
- Routines have been dictated, or others living in his or her household overruled the member's choices.

To support these outcomes, the care manager should be aware of the member's preferences with regards to his or her daily routine, and encourage the member to make decisions. The care manager should assist in working out compromises when the member resides in group setting and the preferences of the member conflict with those of others. The care manager should encourage providers to be flexible in order to accommodate changes that the members may request.

The support *is* present if:
- The care manager is knowledgeable of the member's preferences for daily routines; *and*
- The care manager or provider is making accommodations to honor the member's preferences.

The support *is not* present if:
- The care manager does not know who made the choices for the member regarding daily routines;
- The care manager does not know the member's preferences;
- The care manager has not offered options to the member;
- The care manager is not actively seeking ways to increase the opportunity for the member to make choices when options are limited; *or*
- The care manager is not actively planning for ways to accommodate the member's preferences.

The levels of outcomes and support for this outcome were among the highest in both the baseline assessment and the 2001 assessment. The differences in the levels of outcomes and supports among the three target groups are statistically insignificant.



6. People achieve their employment objectives.

Finding and choosing a job and a career is an important life decision. People can have productive lives with or without paid employment, if they have meaningful activities that provide similar social and personal rewards. People should have the opportunity to consider a range of choices such as paid employment, volunteering, continued learning, or leisure activities.

The outcome *is* present if:
- The member has the opportunity to experience different options; *and*
- The member has decided where to work or what to do.

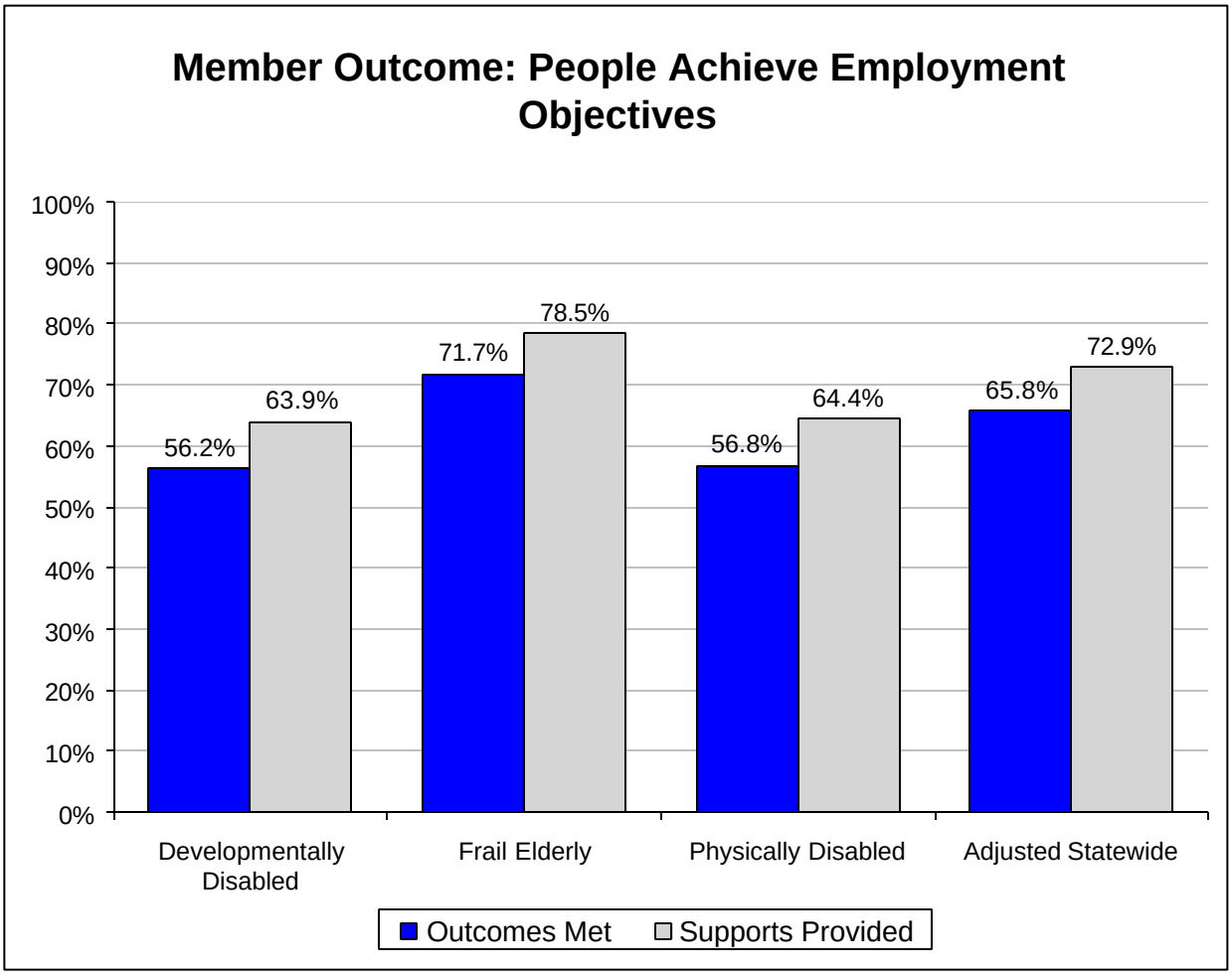
The outcome *is not* present if:
- The member wants to work but does not know how to access the job market;
- The member has not been presented with options of where to work;
- The member is not working in a preferred career or volunteer activity for a preferred organization, or for the preferred hours; *or*
- The member does not have enough activities to provide him or her with a meaningful day.

To support these outcomes, the care manager should learn about the member's preferences, interests, and desires for work or meaningful activities and about the member's skills. If the preferred option is not available, the care manager should have a plan in place to assist the member in identifying the next best alternative. The care manager should assist the member in locating assistive technology devices or supporting environmental adaptations.

The support *is* present if:
- The care manager knows the member's interest for work or is making efforts to learn what the member would like to do;
- The care manager provides the member with access to varied job experiences and options;
- The care manager responds to the member's desires for pursuing specific work or career options with supports; *and*
- The care manager supports the person in addressing any identified barriers to achieving the outcome of where to work.

The support *is not* present if:
- The care manager does not know who made the choices regarding the member's work situation;
- The care manager does not know the member's desires for working situations;
- No plan is in place to address the member's preferences or barriers with regards to work; *or*
- The member has not been provided with options for work or meaningful activities.

The levels at which this outcome was present and the levels of supports provided for achieving members' individual employment objectives were among the lowest of any of the outcomes, although they improved somewhat between the baseline measurement and the 2001 measurement. The outcome was present most frequently for elderly individuals (71.7 percent), and least for members with developmental disabilities (56.2, up from 34.2 percent in the baseline). Among all target groups, the outcome increased from 59.2 percent in the baseline to 65.8 percent in the 2001 measurement; supports increased from 59.8 percent to 72.9 percent.



7. People are satisfied with services.

Satisfaction as defined by the person is a key to quality of services and supports. Satisfaction is related to what people think of services and supports, what their expectations are, and what else they want for the future. Satisfaction does not necessarily mean getting everything you want, but it is more likely to occur when people feel that they are seen as important and treated with respect. The absence of a complaint does not mean the member is satisfied.

The outcome is present if:

- Services and supports are provided to meet the member's expectations and needs.

The outcome is not present if:

- The member perceives a gap between expectations and what is actually happening;
- The CMO is not able to provide all needed services to the member;
- Options have not been presented; or
- The member has lodged a complaint that has not been addressed to his or her satisfaction.

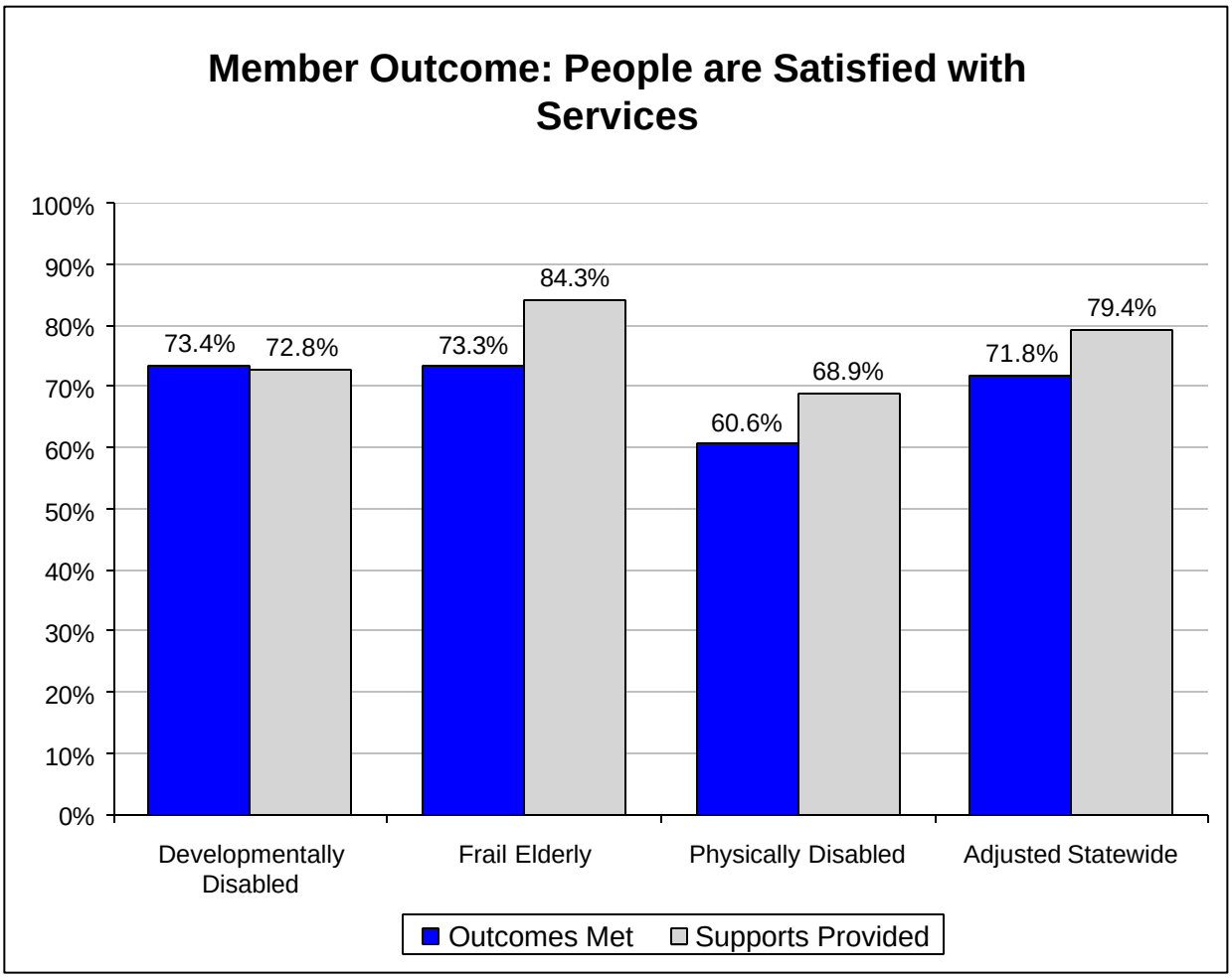
To support these outcomes, the care manager should solicit the member's opinions about services and supports and respond to what is learned. The care manager should anticipate the need to modify services and supports as the member grows or changes over time. Options for changing services and supports should be provided if the member expresses dissatisfaction.

The support is present if:

- The care manager actively solicits the member's opinions about services and supports;
- The care manager responds to the member's feedback regarding supports and services; and
- Changes or modifications are made to increase the member's satisfaction.

The support is not present if:

- The care manager does not know the member's opinions regarding services or supports;
- The care manager is unaware of specific issues with providers; or
- There is no plan to implement changes if the member is dissatisfied.


Member Outcome: People are Satisfied with Services
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73.4%
72.8%
73.3%
84.3%
60.6%
68.9%
71.8%
79.4%
Developmentally Disabled
Frail Elderly
Physically Disabled
Adjusted Statewide
Outcomes Met
Supports Provided

Community Integration Outcomes

8. People choose where and with whom they live.

Choice of a living situation is important in all people's lives. People should be able to choose their living arrangement, location, and the person with whom they live if they prefer to live with others. People need opportunities to see what is available and to make informed choices.

The outcome *is* present if:
- The member was provided with options about where and with whom to live;
- The member decided where to live; *and*
- The member selected with whom to live.

If the member did not originally choose his or her living situation, but decides to remain there after options have been presented, the outcome may be met.

The outcome *is not* present if:
- Decisions of where or with whom the member will live have been made by others without the member's own choices being solicited and considered;
- Options are limited due to lack of accessibility; *or*
- The member is not living where he or she wants to live or with whom he or she would like to live.

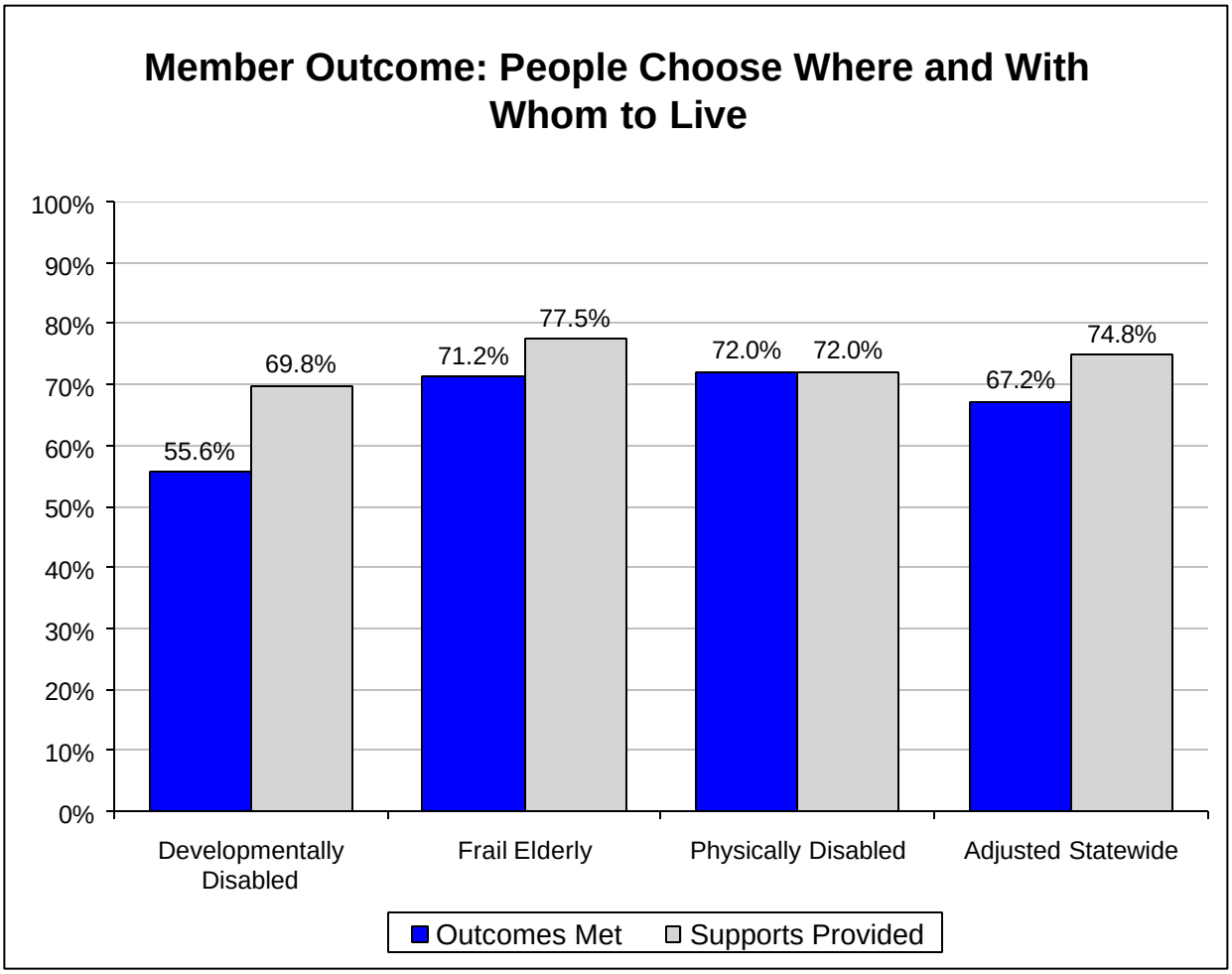
To support these outcomes, the care manager should be aware of the member's preferences in living situations and should inform the member of available options. When options are limited for reasons such as local availability, the care manager should have a plan in place to achieve the outcome, and assist the member in finding the next best situation, including making changes to the member's current living situation. The care manager should also look at ways to reduce financial or regulatory barriers so that more options become available.

The support *is* present if:
- The care manager knows the member's preferences about where and with whom to live;
- The care manager is supporting the member in exploring options and in making informed decisions; *and*
- The care manager acknowledges the member's preferences and supports him or her to address any barriers that prevent the member from living where and with whom he or she wants.

The support *is not* present if:
- The care manager does not know who made the choices regarding the member's living situation;
- The care manager does not know the member's preferences;

- No plan is in place to accommodate the member's preferences; *or*
- Options have not been explored with the member.

As in the baseline measurement of 'People choose where and with whom to live,' for no other outcome was the difference between the results for members with developmental disabilities and those for the other two target groups more pronounced. However, the CMOs did achieve improvement between the two measurements—for individuals with developmental disabilities, 37.8 percent were found to have this outcome present at the time of the baseline measurement. In 2001, the outcome was found to be present for 55.6 percent. Supports for this group increased markedly, from 32.4 percent to 69.8 percent.



9. People participate in the life of the community.

The community has many resources for personal support, enjoyment, and personal development. When people go out in the community they meet other people, learn, and broaden their experiences. Generic community resources, such as doctors, restaurants, banks, grocery and retail stores, should be the preferred choice for health, leisure, and routine daily living activities.

The outcome *is* present if:

- The member is aware of the options available to all others in the community; *and*
- The member indicates that the type and frequency of participation in the community is satisfactory.

If the opportunities for the member to participate in the life of the community are limited only by the size and location of the community, then the outcome is present as long as the member is aware of the limited opportunities available.

The outcome *is not* present if:

- The member is not participating in the community as much as he or she would like to; *or*
- The member has not been able to attend an activity he or she would like to due to lack of available transportation or staff to assist the member, or because the member could not afford the cost of the activity.

To support these outcomes, the care manager should be aware of the member's preferences and interests regarding type and frequency of community activities, provide information about and access to community activities and resources, and provide assistance with transportation if needed. The care manager should tailor supports according to each member's interests and preferences regarding community activities.

The support *is* present if:

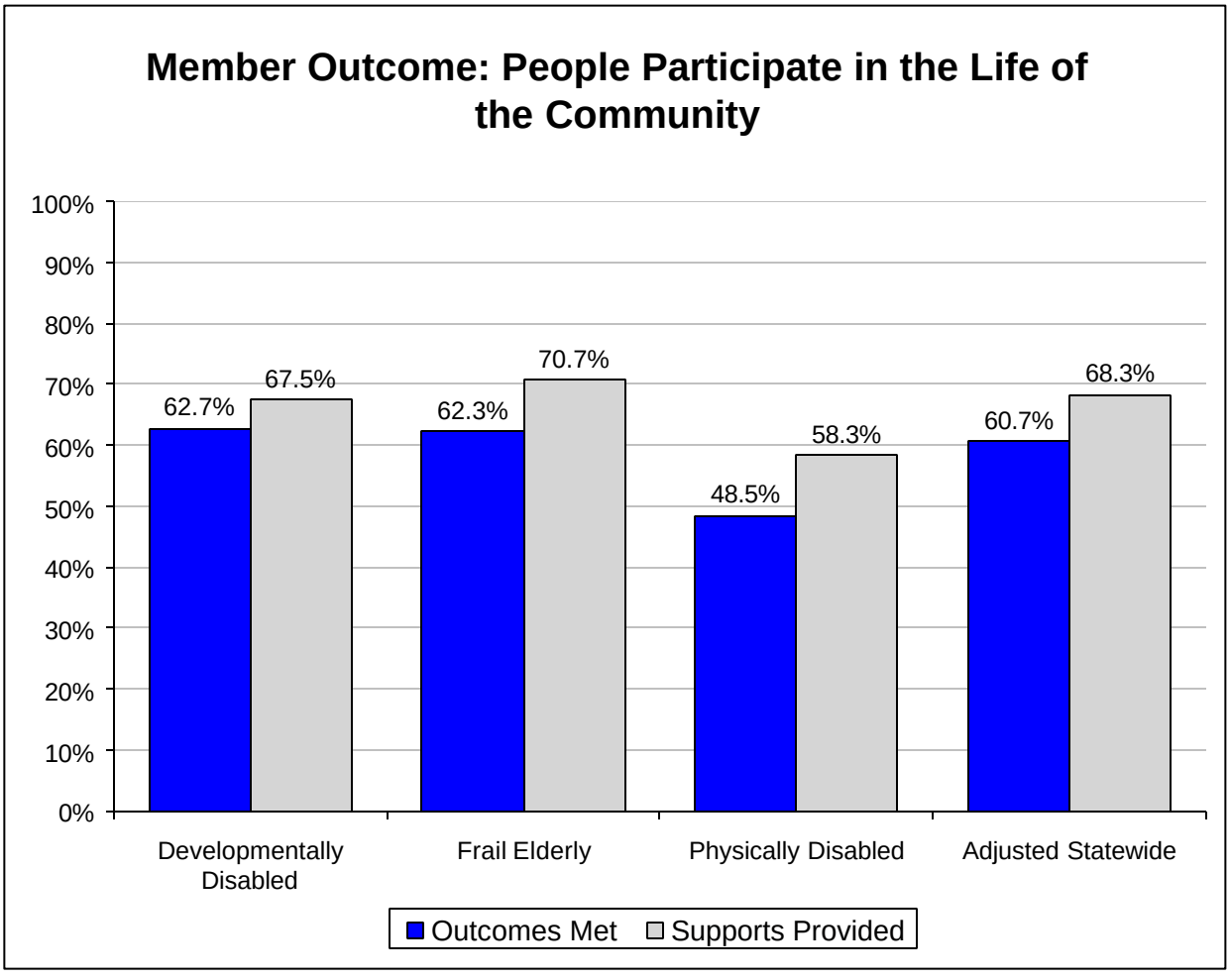
- The care manager knows the member's preferences regarding type and frequency of community participation or is making efforts to learn about the member's preferences;
- The care manager provides information about options for community participation; *and*
- The care manager provides support to the member to do the things he or she would like to do.

The support *is not* present if:

- The care manager does not know the member's preferences regarding type and frequency of community participation and is not making efforts to learn them;
- The care manager has not provided information on options for activities or transportation services; *or*

- The care manager is not assisting the member by addressing staff shortages or financial barriers.

Although these results are not among the highest results when compared to other outcomes, results for each group improved between the baseline measurement and the 2001 measurement. For members with developmental disabilities, outcomes increased from 49.5 to 62.7 percent, and supports increased from 52.3 to 67.5 percent. For frail elderly members, outcomes increased from 59.0 to 62.3 percent, and supports increased from 57.8 percent to 70.7 percent. Although outcomes and supports for members with physical disabilities also increased, the differences between the baseline measurement and the 2001 measurement were not significant. The relatively lower levels of both outcomes and supports for members with physical disabilities indicates that the area could receive additional attention.



10. People remain connected to informal support networks.

Informal support networks are groups of people, such as family and close friends, whose support of each other is usually lifelong and results in security and the provision of a safety net to the person. Informal support cannot be created or manufactured, but can be nurtured as people and relationships grow and evolve. Time, age, and distance can affect how well people remain connected.

The outcome *is* present if:

- The member is in contact with people who provide informal support as frequently as is satisfactory to the member; *or*
- The member does not have an informal support network due to personal choice or natural circumstances.

The outcome *is not* present if:

- The member desires more or less contact with people who provide informal support; *or*
- The member is not receiving needed assistance in contacting people who can provide informal support.

To support these outcomes, the care manager should be aware of the member's informal support network and the member's preferences for staying involved. If the member desires, the care manager should assist the member in re-establishing contact with family members and developing and maintaining an informal support network.

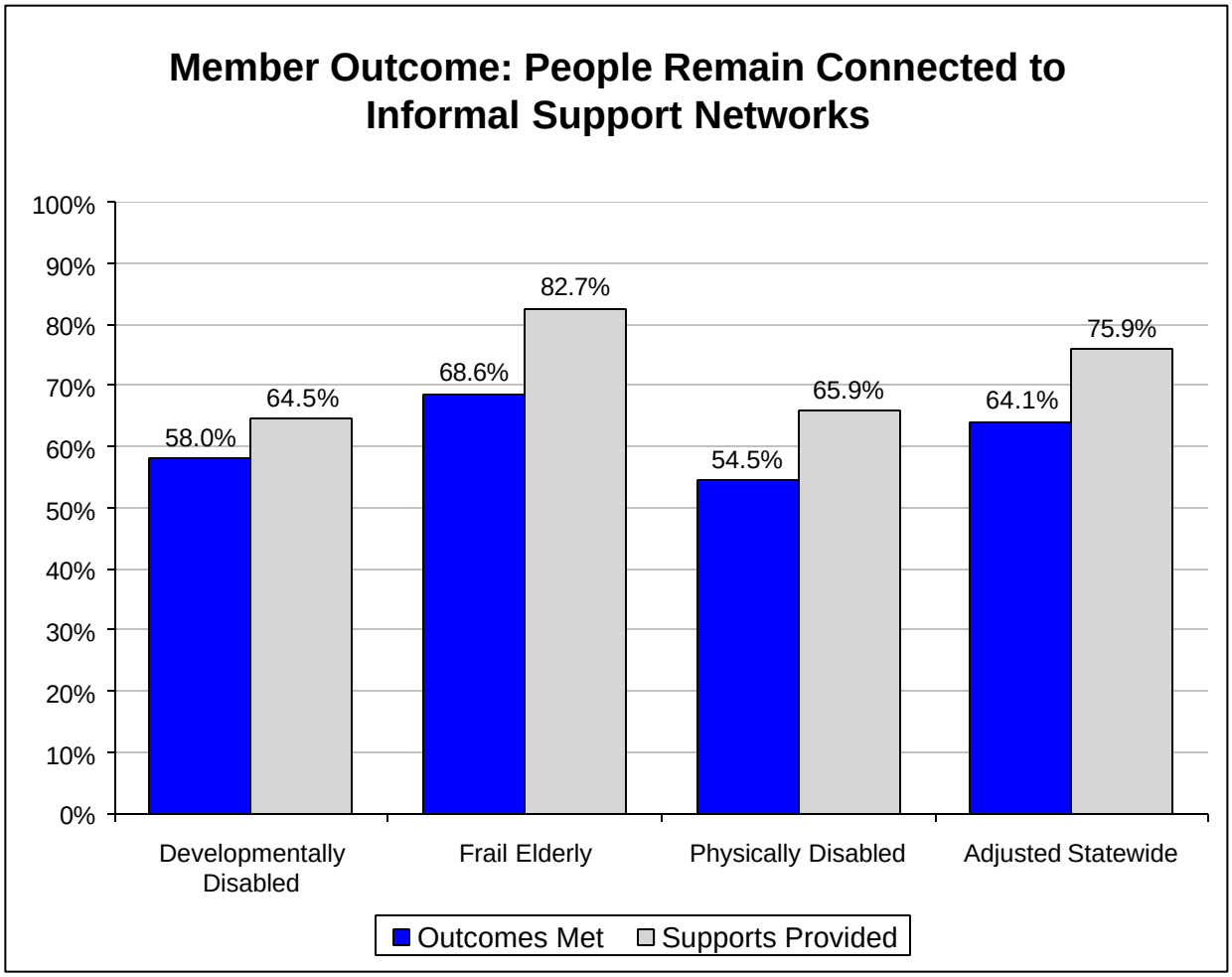
The support *is* present if:

- The care manager can identify the member's informal support network;
- The care manager knows the status of relationships within the informal support network; *and*
- The care manager provides support for the member's relationships within the network if needed and requested.

The support *is not* present if:

- The care manager does not know who provides informal support to the member;
- The care manager does not have a plan to assist the member in maintaining the contact with people who provide informal support; *or*
- The care manager is not aware of the member's need to contact people who provide informal support.

For individuals with developmental disabilities and frail elderly members, the percentage of outcomes present increased slightly, though perhaps not significantly, over the baseline measurement. However, supports present increased for the program as a whole, as supports for this outcome increased from 64.8 percent in the baseline measurement to 75.9 percent in 2001.



Health and Safety Outcomes

11. People are free from abuse and neglect.

Treating people with dignity and respect requires that they are free from abuse and neglect. Actions and practices that may constitute abuse and neglect need to be functionally defined and understood. Abuse is defined and measured according to the person's experience, regardless of when it occurred.

The outcome is present if:

- There are no allegations of abuse or neglect by or on behalf of the member;
- There is no evidence that the member has been abused, neglected or exploited; and
- The member is not experiencing personal distress from a previous occurrence of abuse.

The outcome is not present if:

- The member has reported any allegation of abuse or neglect or there are indications of abuse or neglect;
- The member is experiencing personal distress from a previous occurrence of abuse; or
- The member is unaware of the reporting procedure for abuse and neglect.

To support these outcomes, the care manager should define and expressly prohibit abuse and neglect. The care manager should develop a program of supports to prevent situations conducive to abuse and neglect. Such programs could train members and staff to recognize and report any suspected incidents of abuse and neglect. The care manager should also implement policies and procedures for initiating intervention and investigation in all alleged cases of neglect or abuse, within or outside of the CMO.

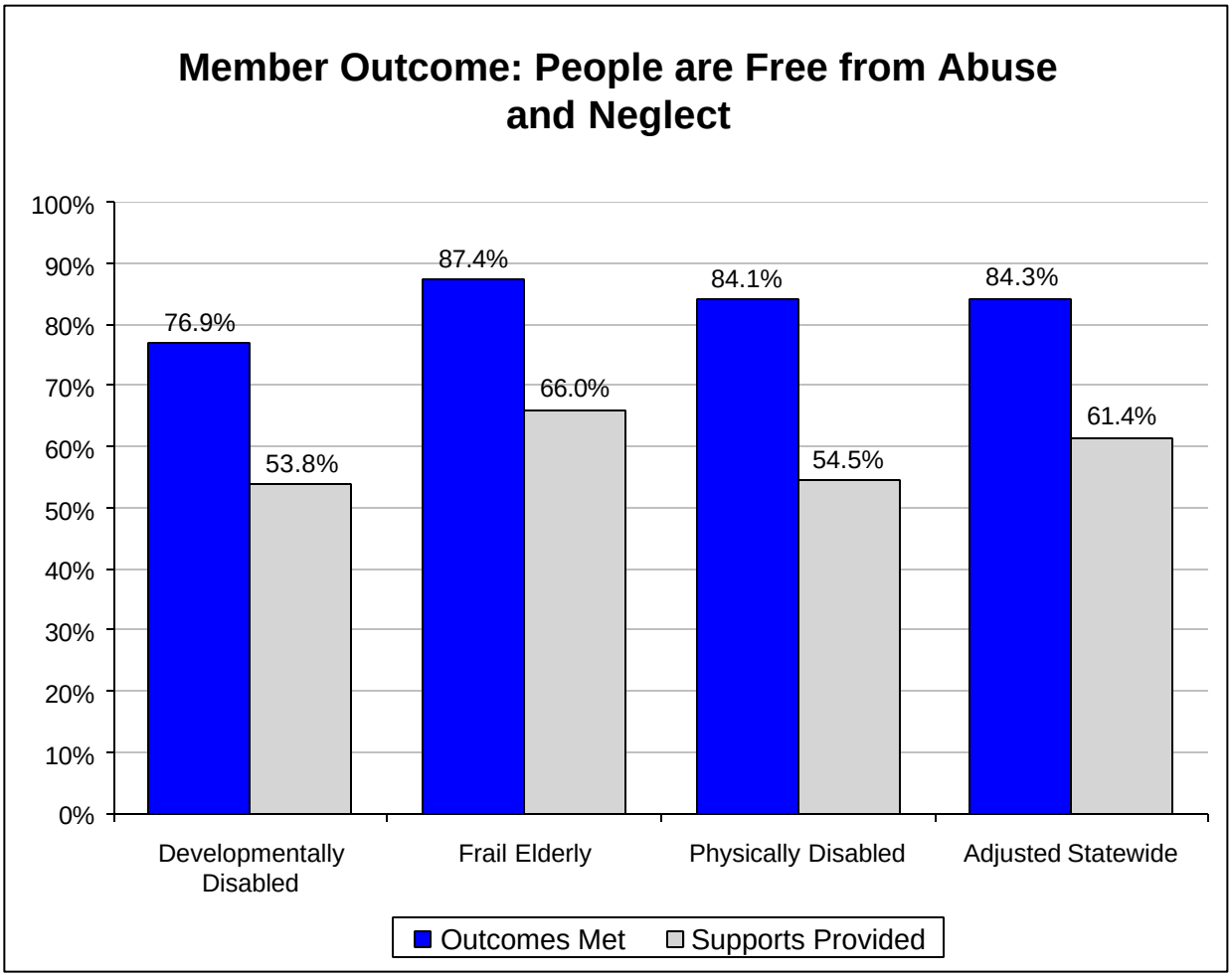
The support is present if:

- The care manager knows the member's concerns regarding abuse or neglect;
- The care manager provides the member with information and education about abuse and neglect; and
- The care manager provides support for the member if he or she has expressed concerns about, or if there have been occurrences of, abuse or neglect.

The support is not present if:

- The care manager does not know whether the member has concerns regarding abuse or neglect;
- The care manager has not provided the member with training and education regarding abuse or neglect; or
- The care manager has no mechanism to provide intervention in situations where staff suspect that the member is or may be at risk for harm.

For this outcome, as in the baseline measurement, the difference between the level of support provided (61.4 percent) and the level of outcomes present (84.3 percent) is remarkable. Even in the absence of complaints or signs of problems, care managers can more actively seek information about each member's perceptions of abuse and neglect to ensure that members remain safe and continue to feel safe. Further attention should be focused on the decrease in supports present for individuals with physical disabilities, as the rate dropped from 70.4 percent in the baseline to 54.5 percent in 2001.



12. People have the best possible health.

Best possible health must be defined in terms that are satisfactory to the member. The definition of "best possible health" depends on the current health status of the member and the possibility of health interventions to restore lost capacity, provide stabilization or minimize further loss of function. Health care interventions should be personalized and effective. Frail elderly people and people with disabilities should have access to health care services of the same variety and quality available to others.

The outcome *is* present if:

- The member sees a health care provider regularly;
- Health care professionals have identified the member's best possible health; and are addressing any health care issues, or concerns, and interventions;
- Health intervention services were selected by the member in consultation with the health care professional;
- Health intervention services as desired by the member have been effective; *and*
- The member has needed devices or equipment such as glasses, hearing aids or dentures that are in good repair.

If any of the above are not present as the result of the member's personal choice, the outcome may still be present.

The outcome *is not* present if:

- The best possible health situation for the member has not been identified or met;
- Health interventions have not been defined in collaboration between the member and a health care provider; *or*
- Needed devices or equipment are not available or are in bad repair.

To support these outcomes, the CMO should define best possible health that is satisfactory for the member. The care manager should provide the member with choices among health care providers and education about the availability of providers and services. Members should be provided with access to preventative screening and diagnostic testing, and with support towards self-managing and directing their own health care.

The support *is* present if:

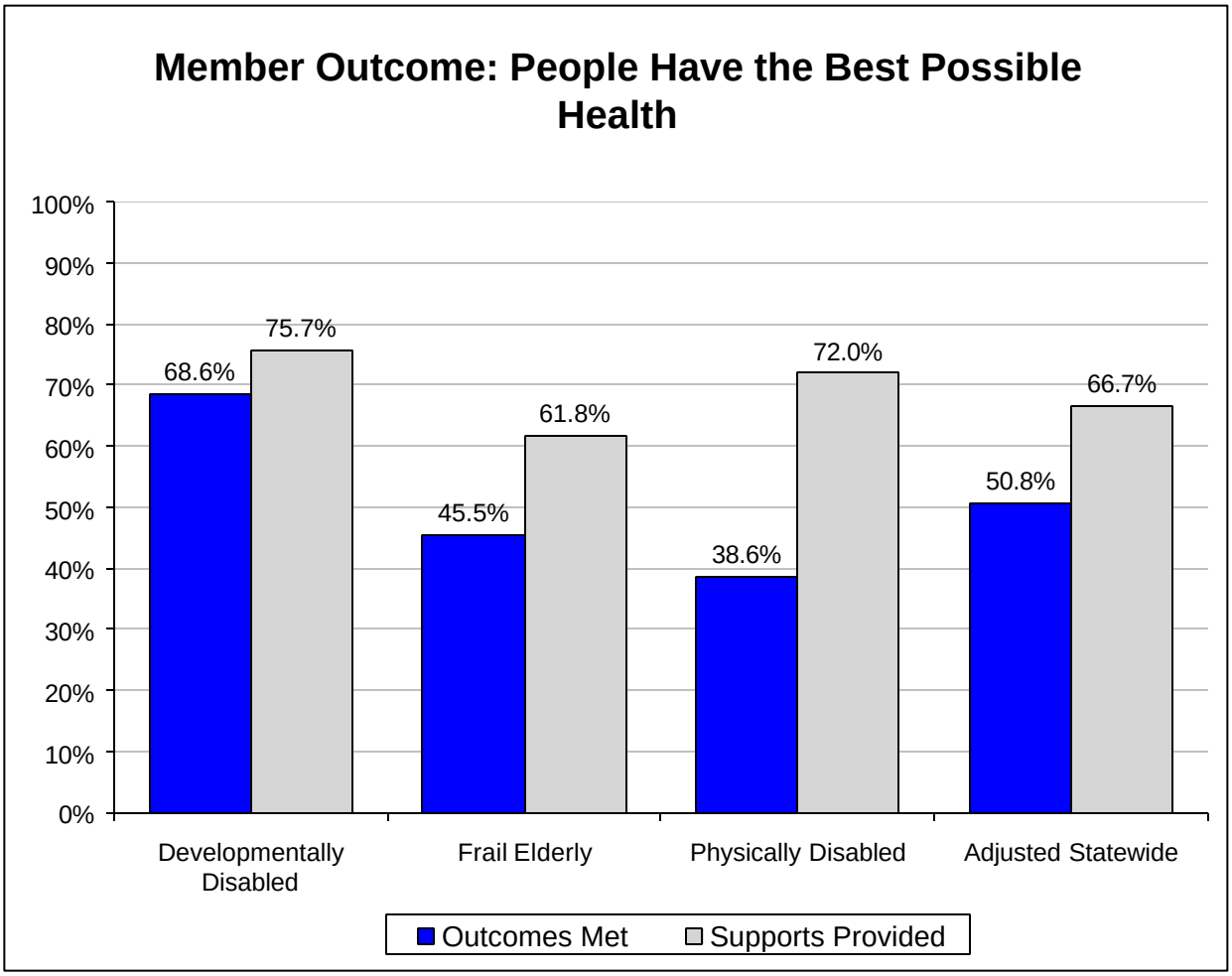
- The care manager knows the member's defined best possible health;
- Any supports that the member needs and has requested to promote and maintain best possible health have been provided; *and*
- The care manager responds to the member's changing health needs and preferences.

The support *is not* present if:

- The care manager does not know the member's defined best possible health;
- No mechanism exists to promote or maintain the member's best possible health;

- The care manager is not responsive to the changing health needs and preferences of the member; *or*
- The care manager does not support the member in obtaining regular medical and dental services.

The low rates at which this outcome was found to be present for members with physical disabilities and for frail elderly members—and therefore for the program overall—will need the attention of the Department and the CMOs.



13. People are safe.

Each of us needs to feel safe from danger in our homes, workplaces, neighborhoods, and communities. People rely on regulations and inspections to ensure standards are met in certain settings to ensure safety, and they rely on personal actions (such as installing smoke detectors or security alarm systems) to feel safe in other settings. However, normal environments contain a reasonable amount of risk, and overprotection can prevent people from leading a fulfilling life.

The outcome *is* present if:

- The member lives, works, and pursues leisure activities in environments that are safe;
- The member knows how to respond in the event of an emergency situation; *and*
- Assistance is available to a member who cannot evacuate independently in emergency situations.

The outcome *is not* present if:

- The member does not have working smoke detectors or fire alarms, a fire escape plan, or working emergency alert devices (for example, LifeLine);
- The member does not feel safe in the neighborhood; *or*
- The member does not know what to do in the event of an emergency.

To support these outcomes, care managers should be aware of the member's preferences regarding safety and should make attempts to ensure the member's safety. The CMO should address all safety concerns, even when the member may not fully recognize the dangers or hazards. Members should receive assistance in anticipating, recognizing, and taking care of safety issues.

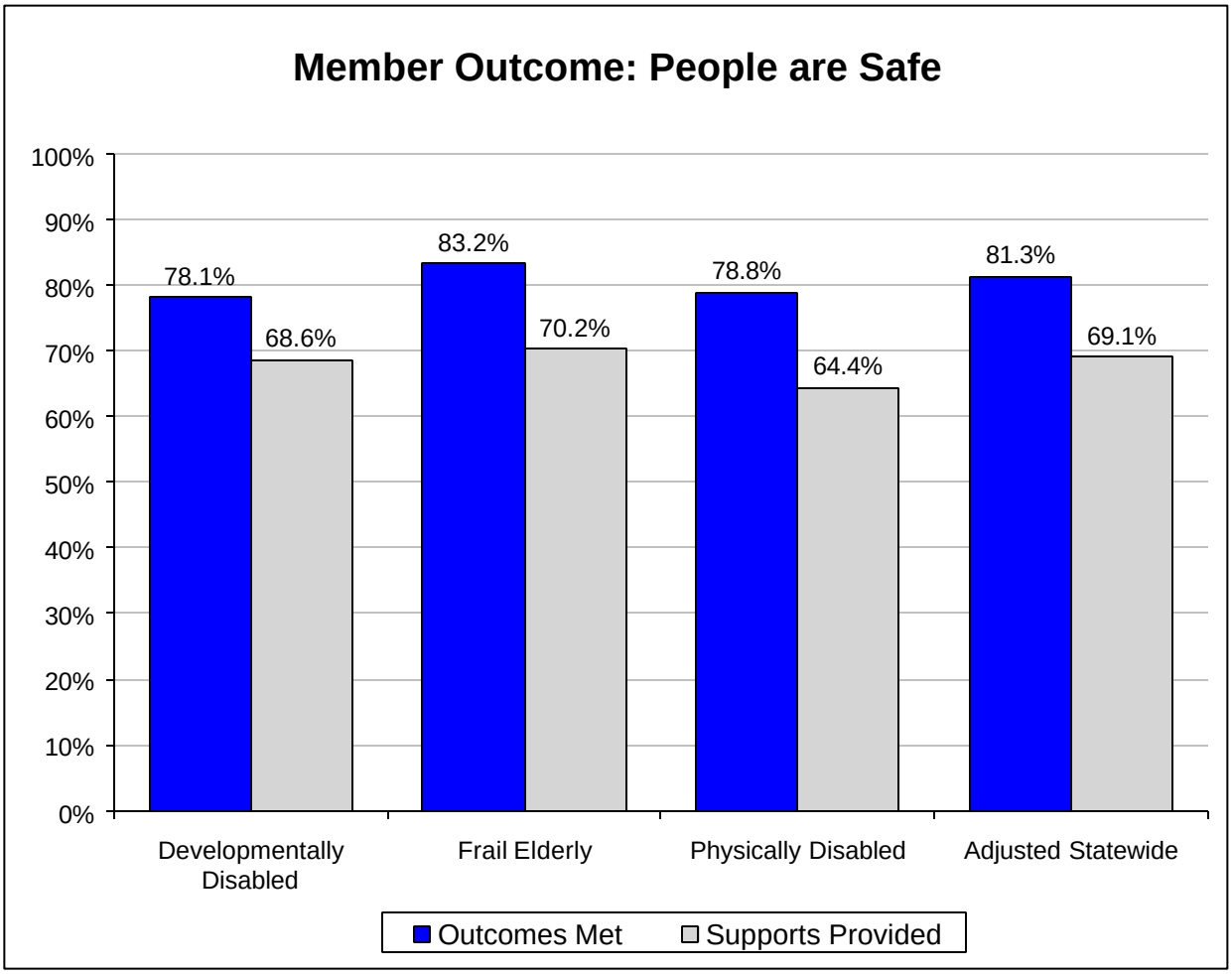
The support *is* present if:

- The member's safety issues have been identified; *and*
- The member has been provided with supports to address safety concerns if needed and requested.

The support *is not* present if:

- The care manager is not aware of the member's preferences regarding safety or whether the member knows how to respond in emergency situations;
- No plan is in place to address identified safety concerns;
- The care manager does not know whether the safety equipment in the member's home is in working order; *or*
- Safety issues have not been discussed with the member.

In general, results for this outcome increased between the baseline measurement and the 2001 measurement, although only for frail elderly members was the improvement large. In the baseline measurement, this outcome was present for 71.1 percent of the frail elderly members; in 2001, it was found to be present for 83.2 percent. Levels of support appear relatively consistent among the three target groups.



14. People experience continuity and security.

Change can contribute to happiness or discontent. Understanding and recognizing the emotional impact of change on a member is vital to providing consumer-centered services and supports. Economic security plays a significant role in enabling members to plan for the future. People should be included in all relevant decisions that impact their lives.

The outcome *is* present if:

- Changes experienced by the member over the past one to two years have been planned and controlled by the member or have not been upsetting to the member;
- The member's control over changes is similar to that exercised by other people; *and*
- The member has economic resources to meet his or her basic needs.

The outcome *is not* present if:

- The member has not been involved in planning for the changes;
- Changes were not based on the member's personal goals;
- The member does not have insurance or a plan to cover belongings in case of fire, theft, flood, or other losses;
- The member does not feel financially comfortable; *or*
- The member has been experiencing a lack of continuity of staff providing services.

To support these outcomes, the care manager should seek to understand how the member defines and reacts to change. The care manager should involve the member to the best of his or her ability in making decisions. The care manager should also take measures to ensure that member's economic resources are protected.

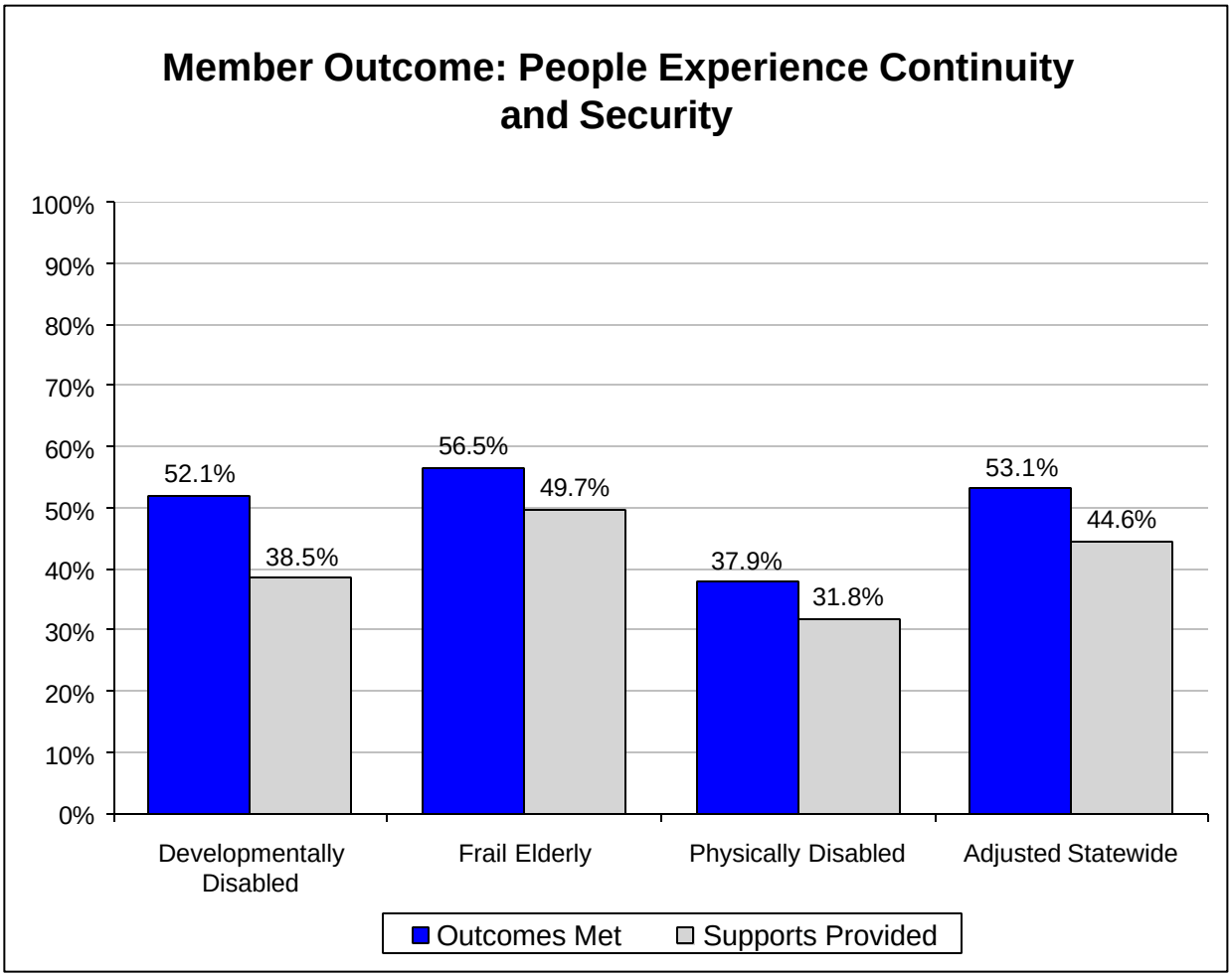
The support *is* present if:

- The care manager knows what the member requires to experience continuity and security or is demonstrating efforts to learn about the member's preferences; *and*
- The care manager has been providing support to the member in attaining and maintaining continuity and security.

The support *is not* present if:

- The care manager does not know the member's needs and preferences regarding continuity, security, and financial resources;
- No plan is in place to support the member in attaining and maintaining continuity and security; *or*
- The care manager does not know whether the member has insurance to cover belongings or a burial trust.

The Department and the CMOs will need to examine these results closely. The level of supports provided was the lowest among all 14 outcomes, for the program as a whole and for each target group individually. The level at which the outcomes were found to be present was the lowest among all 14 outcomes for both developmental disability and physical disability target groups. Written comments by the interviewers indicate that the problem may lie largely with the frequency with which care managers ensure that members have adequate insurance. If this is the case, the Department will need to consider, among other possibilities, whether the outcome tool serves as a valid reflection of the members' most pressing concerns.



The Next Steps

This information does not provide a definitive scorecard of the CMOs' performance—it is too soon and we do not yet have the basis for establishing benchmarks or expectations. The information in this report is only a starting point that provides important context for other quality assurance efforts, such as the review of individual service plans, annual quality site visits, and review of each CMO's performance improvement plans.

Lack of benchmarks

These results cannot be considered to be a numeric report card of the CMOs' performance for several reasons. First, the Department has not yet identified benchmarks or targets for each outcome. No one can expect complete attainment of all outcomes—it is unrealistic to expect that all desired outcomes will be present at any given time for any individual, either with or without a need for long-term care.

The Department expects, however, that it will be possible to identify performance benchmarks after additional data from Family Care and from other programs are accumulated to provide a basis for comparison. One important advantage in using these assessment methods is that the Council's years of work have created a well-documented body of information about national consumer outcomes that will serve as a basis for comparison with Family Care results. In addition, we are accumulating results for other programs that will be useful for assessing realistic benchmarks. To date, we have completed two rounds of member-outcome interviews for Family Care members and one round of member-outcome assessment for the Partnership and PACE programs, and member-outcome interviews are currently underway for a randomly selected statewide sample of home-and-community-based waiver participants.

Evolving measurement process

Second, the measurement process itself is still evolving. Although the Council's experience provided a deep and well-developed body of experience on which to build, this approach to quality assessment is still young. BALTCR staff and elderly consumers contributed to the adaptation of the measurement tool for use with frail elderly individuals, but the set of 14 outcomes and the associated decision-making questions have not yet been systematically validated as measures of quality-of-life for frail elders. (See the Appendix for a copy of the current assessment tool.) Planning is currently underway to create a set of outcomes and a measurement tool specifically developed for the frail elderly target group.

In addition, the Department is accumulating experience with the process of carrying out the interviews, which has prompted modifications in each round of interviewing. Modifications have included actions such as changing the instructions provided to care managers before their interviews or the way in which members are invited to participate in the interviews. Although the Department believes that these modifications are leading to a more reliable measurement of outcomes each time, they adversely affect comparability of results between

rounds of interviews. Therefore, the Department has limited the emphasis it places on smaller changes between rounds of interviews, such the increase from 59.2 percent to 65.8 percent for the outcome for 'People achieve their employment objectives.'

The primary value lies in quality assurance.

As noted, the results of the first round of member-outcome interviews provided the Department and the CMOs with detailed, reliable information with which to identify directions for quality improvement efforts. For example, after the first round of member-outcome interviews was completed, the Fond du Lac County CMO was concerned with the level of member outcomes found to be present for members with developmental disabilities in "People choose where and with whom they live." CMO staff then focussed on identifying members' outcomes and additional efforts that could support that outcome for more people. Over the next year, the CMO worked on reducing the size of several residential facilities to provide more private rooms and alternate living situations for members who requested a change. As a result of the efforts of the CMO, the percentage of this CMO's members in this target group with this outcome present doubled between the first round to the second round of member-outcome interviews.

In December 2001, CMOs were provided with the detailed results of the member-outcome interviews for their members, and each CMO discussed these results with the Department. Staff of some CMOs have indicated plans to use the interview results from the second round of member-outcome interviews to assess the level of outcomes and supports for members using self-directed supports, to discuss quality with supported-employment providers, to analyze outcomes by service provider, and to inform staff, governing boards, and various committees and councils. The Department continues to conduct program-level analyses of the results and the process.

More importantly, we hope that focusing on member outcomes will promote consistent attention at all levels to our ultimate purpose: improving the quality of life for people who need the services. At the local level, outcomes-focused care managers and providers will listen to the individuals who receive the services and find flexible, creative ways to provide support for their desired outcomes. At the Department level, outcome-focused staff will find ways to identify and share best practices among local programs to assist them in meeting equally high levels of performance. Outcome-focused state and federal policy makers will be able to direct resources to the most cost-effective programs and priorities.

Finally, looking forward to a time when long-term care consumers are able to exercise more choices among service providers, the Department intends that member outcomes information will help those individuals and their advocates locate and select the best organizations to help them.

Appendix I: Methodology for Outcomes Assessment

Over a 22-week period from May 14, 2001 through November 2, 2001, 492 CMO members were interviewed about their individual preferences related to the 14 Family Care consumer outcomes. Descriptive information about the scope of this assessment is provided in the table below.

Working from a list of 669 randomly chosen members, staff from each CMO contacted members, or guardians for those members with guardians, to ask if the member was willing to participate in the outcome interview. For non-verbal members, care managers or guardians were asked to identify the person who knew the member best to participate in the interview with the member. Participation was voluntary and about 26% of members contacted declined to participate, citing reasons such as "everything is going well," "moving," "no time," or "not interested in participating a second time."

The members or guardians chose the location of the interview; most occurred at members' homes or their place of employment. Interview times were scheduled according to what was convenient for members. On average, interviews lasted just over an hour. Members were allowed to end the interview at any point or to decline to answer questions, and interviewers paid close attention to members' body language and made adjustments if the member seemed to become fatigued during the interview.

The data from the Family Care interviews are representative of member experiences from each of the three target groups served by Family Care CMOs. Eventually, the Department plans to analyze the outcomes data by looking at the characteristics of the members interviewed, the presence of outcomes and individualized supports, the particular differences of the CMOs providing the services and supports, and possibly the differences in communities in which members live. This report does not present those analyses.

Information at a Glance

Number of CMOs	5
Size range of CMOs in April 2001	133-797 members
Number of months in operation	Ranges from 4 – 15 months
Location of CMOs	Metropolitan, suburban, rural
Ownership	Public sector agencies
Total FC enrollment at time of sample	2,571 as of April 2001
Original sample size	669 (26% of total Family Care enrollment)
Number of members interviewed	492 (19% of total Family Care enrollment)
Number of members not interviewed	177 (7% of total Family Care enrollment)
Number of members in Round 1 and 2	149 (22% of sample)
Participated in both rounds	81 (12% of sample)
Participated in Round 2 but not Round 1	20 (3% of sample)
Did not participate in either round	22 (3% of Sample)
Participated in Round 1 but not in Round 2	26 (4% of Sample)

Living situations	All types
Gender	
Females:	318 (64.6%)
Males:	174 (35.4%)
Age	
Under 18	0
18 – 21	20
22 – 39	87
40 – 59	144
60 – 84	193
85 and over	48
People with developmental disabilities	169 (34.3%)
People with physical disabilities	133 (27.0%)
People with frailties of aging	190 (38.6%)
Average time to complete member interview	63 minutes
Average time to complete follow up interview	38 minutes
Communication capabilities	
Member spoke on own behalf	309
Member spoke on own behalf with some assistance from another	123
Someone spoke on behalf of member	60
Sign Language Interpreter	2
Translator	
Hmong	7
Russian	2
Spanish	4
Arabic	1
Serbian	1
Interviewers	
State staff with expertise in working with people with developmental disabilities	3
Contracted staff with expertise in assessing the quality of home and community-based waiver programs for people who are elderly or who have a physical disability	6

Member Assessment Interview Method and Tool

The interview method was developed by The Council on Quality and Leadership as a way to assess how quality of life for people with disabilities is affected by public services in the context of each individual's preferences about services. The tool, which can be found at the end of this report, was adapted for use in Wisconsin and for each of the CMO target groups by the Department of Health and Family Services.

The interviewer may ask a series of questions or simply let the individual speak about issues on his or her mind, directing the conversation to cover all the areas required. One member may be asked different questions than are asked of another member. If a member is non-verbal, the interviewer will observe the member in his or her living arrangement and pose questions to the member and allow a relative or guardian who knows the member best to respond on the member's behalf. A method was devised to address health and safety concerns in case an interviewer noted a critical problem while meeting with a member. Interviewers were instructed to ensure the safety of the member by immediately discussing health and safety issues with the care manager.

Next, the interviewer meets with a representative of the interdisciplinary team, responsible for coordinating the services and supports for that Family Care member. During this meeting, the representative may access case records for the individual to assist in responding to the questions. After both meetings are complete, the interviewer uses the interview tool to assess whether outcomes were present for the member and whether supports were provided by the CMO.

Sample Selection

The sample was selected using SPSS software drawing a random sample without replacement within each CMO and within the three target groups. The sample size was determined according to the number of members enrolled in each CMO by each target group, using a sample size calculator with a 95 percent confidence level and $\pm$ 5 percent confidence interval. Because some individuals were unable or unwilling to participate in the interviews, confidence intervals for the results for some target groups and for each CMO individually may be greater than $\pm$ 5 percent.

Interviewer Training

Interviews were conducted by trained interviewers who achieved at least 85% inter-rater reliability in pre-interview testing. Staff from the Bureau of Developmental Disability Services (BDDS) and from The Management Group (TMG), a contractor with the Bureau on Aging and Long-Term Care Resources (BALTCR), were trained and tested for reliability in November 2000. Wisconsin staff participate in periodic re-testing sessions with senior staff from the Council to maintain inter-rater reliability. In addition, interviewers meet via conference call regularly during the interview process to help maintain consistency across the interview sample.

Member Outcomes Interview Tool for Family Care

The purpose of this document is to add additional support to the interview process. The questions in this tool are selected from The Council on Quality and Leadership's Personal Outcomes Measures 2000 edition manual (for a listing of all of the suggested questions see the manual). These questions are to be used like the manual in picking and choosing the right questions to ask people in order to get the information needed to make decisions about the presence or absence of outcomes and supports. This list is not all-inclusive, and all questions listed will not be asked of every member. **Supplemental questions were developed with input from focus groups from BDDS and BALTCR, reviewed by The Council and compiled on 11/6/00.*

Outcome: People choose where and with whom they live.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. How did you choose where to live? 2. What options did you have to choose from? 3. How did you decide who would live with you? 4. What do you like about your living situation? 5. What would you like to be different?	*1. Does the person have options about where/with whom to live?* *2. Does the person decide where to live?* *3. Does the person select with whom he/she lives?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. How many different residential options were shown to you? Did you visit different places before you chose where to live? 2. Did you decide to live here or did someone else? Who? 3. Did you have a choice of your roommates/ housemates? 4. Where did you live before moving here? 5. What do you like about living in your current situation? Do you dislike anything? 6. If you are not living where you want to live, is a plan in place to help you move? 7. Do your supports (family, legal guardian, caregivers, etc.) know your preference about where to live? And with whom? 8. For individuals with whom the courts have intervened, is there a rationale behind where the person is currently living versus their preference?	**(for people in substitute care facility or with family, others)** 1. How did you choose where to live? With whom you would live? 2. What do you like about your living situation? What don't you like? **(for people living in their own home)** 1. What do you like about your living situation? What don't you like? 2. What would you like to be different? 3. Where do you want to live? 4. Have you ever told anyone about wanting to move, make changes, etc? Do you know what type of setting you would like to move to? 5. Are you worried that you will not be able to remain in your own home? What worries you? 6. Do you think you have received enough help to live in your own home?	**(for people in substitute care facility or with family, others)** 1. How did you choose where to live? 2. What options did you choose from? 3. What do you like about your living situation? What don't you like? 4. What would you like to be different? 5. Do you consider your current living arrangement home? **(for people living in their own home)** 1. What do you like about your living situation? What don't you like? 2. What would you like to be different? 3. Where do you want to live? 4. Do you wish to move, make changes, etc? Do you know what type of setting you would like to move to? 5. Are you worried that you will not be able to remain in your home? What worries you? 6. Do you need more help to live in your own home?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you learn about the person's preferences? 2. How do you present options so the person can make informed choices? 3. Is the person living where/with whom they wish? 4. What are you doing to overcome barriers?	*1. Does the organization know where/with whom the person wants to live or are there efforts being made to learn about the person's preference?* *2. Does the organization support the person to explore all options so he/she can make informed choices?* 3. *Does the organization acknowledge the person's preferences and support the person to address any barriers that prevent him/her from choosing where/with whom to live?*

Outcome: People achieve their employment objectives.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. What do you do for work/career? 2. What options did you have? 3. Who chose what you do? 4. Can you do something different if you want? 5. How did others help you with this?	*1. Does the person have the opportunity to experience different options?* *2. Does the person decide where to work/what to do?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Can you tell me what you do during the day? 2. Do you do what you want with your days? 3. Are you retired? Do you like retirement? Are you doing things during the day that you want to do? 4. Do you have a job? If no, do you want to work? If you want to work, are there any things that get in your way? 5. Do you like your job? 6. What would be your favorite job to do? 7. Would you like more hours? 8. Do you have the educational or training opportunities you want? 9. Do you have any concerns about losing benefits if you work? Are you working to your full potential? 10. Do you have opportunities for advancement? Job transfers? 11. Do you have adequate transportation to get to work? Job interviews? 12. If you need a job coach, can you get one? 13. If you are volunteering, was it your choice or was it suggested? If it was suggested, is it a means of getting job experience?	1. What options do you have for spending time doing activities you want to do? 2. Do you work? 3. If no, would you like to work? (What do you think is keeping you from working?) 4. Do you know what you want to do? 5. Do you like the work you currently do? Is this what you want to continue to do?	1. Though work may not be an option that many people who are elderly want, we should ask that question. Some may feel that they do want a job. 2. What do you like to do during the day? Do you get to do the things you like to do? 3. "I understand you used to be a (school teacher). Are things about (teaching) that you would still like to do?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you learn about the person's preferences for work? 2. How do you present options to the person so they can make informed choices? 3. Is the person working where they wish? 4. How are you overcoming any barriers? 5. How do you learn about the person's job satisfaction?	*1. Does the organization know the person's interests for work OR are efforts being made to learn about what the person would like to do?* *2. Does the organization provide the person with access to varied job experiences/options?* *3. Has the organization responded to the person's desires for pursuing specific work/career options with supports?* *4. Has the organization supported the person to address any identified barriers to achieving this outcome?*

Outcome: People are satisfied with services.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. What have you gained from the services you receive? 2. What do you like about the services you receive? 3. What would you like to change? 4. Is there something more you want? 5. How do people find out if you are satisfied with services? 6. How do you let people know you are dissatisfied?	*1. What are the person's expectations/needs for services and supports?* *2. Are services and supports provided to meet the person's expectations and needs?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Are people helpful? 2. Are you comfortable as a participant in Family Care? 3. Is Family Care worthwhile? 4. Behavior changes indicate satisfaction - If someone is speaking for the person be sure to ask why they think someone is satisfied or not. 5. Who checks to make sure that you are pleased with what is going on? 6. Are things in your life better since you enrolled? How? If no, why? 7. If you had a complaint, did the CMO help you resolve it? 8. Would you recommend your providers to others? 9. Would you recommend Family Care to others?	1. What do you like about the services you receive? 2. What don't you like about the services you receive? 3. Are new needs addressed to your satisfaction? When new needs arise, are they met? 4. Did you have to wait for services? If you had to wait, were you comfortable with the length of time and what happened? 5. Did the people accommodate your schedule for meetings? For communication? For care planning? For determining eligibility? 6. Are hours of service flexible to accommodate your schedule?	1. What do you like about the help you receive? What don't you like? 2. What would you like to change about the services you receive? 3. If you are unhappy or disagree with a service, do you know whom you can talk to? 4. Do people do what you want them to? 5. If people come into your home to provide services, is your home and personal belongings respected and kept the way you want? 6. Who do you talk to about the kind of help you need or want? 7. Does you care manager/caregiver/service provider communicate with you in a way you understand? 8. Do you think your care manager/caregiver/ service provider is aware of your needs relating to the type of disability or illness you have?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. What methods have been developed to determine the person's satisfaction with services? 2. What is done to increase satisfaction if the person has concerns? 3. How have you determined the person's expectations for services and supports? 4. Are there any barriers that affect the outcome for the person?	*1. Does the organization actively solicit the person's opinions about services and supports?* *2. Does the organization respond to the person's feedback regarding supports and services?* *3. Are there changes/accommodations made to increase the person's satisfaction?*

Outcome: People choose their daily routine.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. What is your day usually like? 2. What do you do and when? 3. Can you make a change in times you do things to suit your needs? 4. Who decides when you eat meals? 5. Who decides when and how often you bathe?	*1. Does the person have choice about what to do during the day?* *2. Does the person choose when, where, and for how long he/she will engage in routine activities?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Do you have a daily routine? 2. Do you have established ways of doing things? 3. How involved are you in household tasks? 4. Are you able to "sleep in?" 5. If you want to do something special on short notice, can you do so? 6. Is there a required chore list where you live? If you do not participate, what happens? 7. Do you plan your day? How do you do that and who, if anyone, helps you? 8. Is there flexibility in your day according to your preferences?	1. Tell me about your day. 2. Are you able to go to bed when you want? 3. Are you able to wake up/get up when you want? 4. Are services in place to accommodate your schedule? 5. Are you able to continue your usual activities and hobbies with services in place? 6. Are your services and supports in place that allow you to continue your usual activities and hobbies? 7. What happens if you don't want to eat when the others in the house do? 8. Do you have certain hours or days when you are scheduled to have laundry done, take baths, clean your room, etc?	1. Are you able to get up in the morning and go to bed at night when you want? 2. Are you able to eat what you want, when you want? 3. Are you able to bathe when you want? 4. Are you able to wear what you want? 5. Does the help you get support activities that are important to you? 6. Do the help and supports you have in place now support you to continue your usual activities and hobbies (continue to read books, take walks, etc)? 7. Are there rules that you feel you must follow?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you know what the person likes to do and when he/she prefers to do it? 2. How do you learn about the person's preferences for routines and leisure time? 3. How are options explored and experiences provided? 4. How do you honor the personal preferences of the person" 5. Are there any barriers that affect the outcome for the person? How is the person supported to achieve this outcome?	*1. Does the organization know the person's preferences for daily routine?* *2. Does the organization make accommodations to honor the person's preferences?*

Outcome: People have privacy.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. Are there times when you want to be alone? *2.* Where can you go to be alone? 3. Where do you visit with your friends/family in privacy? 4. How do you have privacy when you make personal phone calls? 5. Are there times when you don't have the privacy you want? 6. If you need help with personal hygiene, how do you decide who will help you?	*1. Does the person have time during the day for private activities and general privacy?* *2. Can the person go somewhere to be alone or with friends?* *3. Is privacy provided when the person desired/requests privacy?* *4. Is the person satisfied with the level of privacy?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Do you have your own room? 2. Do you have access to your own room? 3. Do you share a room with someone? Do you choose to share with this person? 4. Do people knock on the door before entering? Can you close your door tightly? 5. Is there a lock on the door? 6. Can you keep your belongings locked up? 7. Can you have private time with whom you want in your bedroom? Are you allowed visitors of the opposite sex in your room? 8. Are family members and friends welcome in your room? 9. Are there house rules that infringe on your privacy? 10. Phone time - can you have private time? Can you have your own phone? 11. Is your personal care done in private? Do you have a choice of who does your personal care? 12. Do you open your own mail? 13. Do you hear people talking about you when they should not? 14. When others assist you by talking to your doctor, is the conversation done in private?	1. Where can you go when you want to be alone? 2. Do you have privacy to visit with or talk on the phone with family and friends? 3. Are there times you don't have the privacy you want? 4. Are there times you are uneasy about sharing information with your caregivers? 5. When you get help taking a bath, getting dressed…is it done as privately as you would like? 6. Are you comfortable with the people who help you? 7. Are services and equipment provided unobtrusively, or in a way that does not draw unwanted attention to your condition?	**(for people in substitute care facility or with family, others)** 1. Do you have a place to go when you want to be alone? 2. Do you have privacy to visit with or talk on the phone with family and friends? 3. Is you mail delivered on time and unopened? **(for all older persons)** 1. Are there times when you do not have the privacy you want? 2. If you receive help taking a bath, getting dressed…is it done as privately as you would like? 3. Are you comfortable with the people who help you complete private tasks? 4. Are there times when you can refuse to share information with your caregiver or other "service providers?" 5. Do your "service providers" call ahead or schedule visits? Do they identify themselves when they visit? 6. Do your "service providers" knock and receive permission before entering your home or living area? Do they respect your right not to want them to come in? (same questions with apartment management) 7. Are your private living areas or belongings left alone? 8. Are services and equipment provided unobtrusively or in a way that does not draw unwanted attentions to your condition?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you learn about the person's desires/needs for privacy? 2. How do you accommodate his/her desires and needs. 3. How are methods to address opportunities for the person's privacy individualized for the person? 4. Are there any barriers that affect this outcome for the person? How is the person supported to address barriers?	*1. Does the organization know the person's preferences for privacy or are efforts being made to learn about preferences?* *2. Does the organization make accommodations to honor the person's preferences?*

Outcome: People participate in the life of the community.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. What kinds of things do you do in the community(shopping, banking, synagogue, church, school, hair care) 2. What kinds of recreational or fun things do you do in the community (movies, sports, restaurants, events) 3. How do you know what there is to do? 4. Who decides where and with whom you go? 5. Is there anything you would like to do in the community that you don't do now? What would you need to make this happen? 6. What supports do you need to participate as often as you'd like in community activities?	*1. What does the person do when he/she participates in the life of the community?* *2. How often does the person participate in the life of the community?* *3. Is this type and frequency of participation satisfactory to the person?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. How often do you go to the grocery store? Do you shop for your own groceries? 2. Do you go into the community to do things? Is it often enough for you? 3. If a special event comes up, can you go to it? 4. Do you have transportation? 5. Do you choose your events? 6. How do you know what is going on? If you need help with learning about upcoming events, who helps you? 7. Are there "typical" events in the community you are able to attend? (church, shopping centers)	1. Do you get out of the house as much as you wish? 2. What things do you like to do in the community? 3. What do you do when you get into the community?	1. What kinds of things do you do when you get out of the house (shopping, banking, church, synagogue, school, hair care)? How often? 2. How do you find out about activities or events going on in your community/area/ neighborhood? 3. Do you decide where and with whom you go out in the community? Do you get out in the community often enough? 4. Is there anything you would like to do with other people that you don't do right now? 5. Is there anything that would make going out of the house more comfortable for you or for people around you? 6. How do you get around? 7. Do you get out in your neighborhood as much as you want to?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How is the person informed of options available in the community? 2. How do you learn about what the person prefers to do ? 3. How do you learn about how often the person likes to be involved in community activities? 4. What supports does the person need to participate in community activities? How are those provided? 5. Are there any barriers That affect this outcome for the person? How do you assist the person in overcoming these barriers?	*1. Does the organization know what the person would like to do in the community OR are efforts being made to learn about the person's preferences?* *2. Does the organization know how often the person would like to engage in community activities OR are efforts being made to learn about the person's preferences?* *3. Does the organization provide the person access to information about options for community participation?* *4. Does the organization provide support to the person to do the things s/he wants to do?*

Outcome: People have personal dignity and respect.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. How does staff treat you? 2. What do you think about things you do at home, school, work? Are they interesting? 3. Do people listen to your comments and concerns? 4. Do you think people treat you as important?	*1. How do others treat the person?* *2. Does this treatment demonstrate respect for the person?* *3. Do interactions with others reflect concern for the person' opinions, feelings, and preferences?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Are you called by the name you prefer to be called? 2. Do others listen to your opinions? Do others ever outvote your decision? 3. Are you able to communicate in another language? Are translators made available? 4. If you have an augmentative communication device, are you permitted to use it? Does it work? 5. Are your cultural beliefs acknowledged? 6. Are you able to use your own strengths? Do you feel rushed by caregivers and not given a chance to perform tasks independently? Are you able to demonstrate mastered skills? 7. Do others talk to you versus your caregiver when you are present? 8. Are you treated as an adult, in an age appropriate manner? 9. Do others knock on the door before entering your room? 10. Does your service plan maximize your potential?	1. Do others talk to you directly or do they talk to others when you are present?	1. Do people call you by your preferred name? 2. Do you feel your opinions are valued and respected? Do your care manager and service providers listen to you? 3. Do you feel people listen to your comments and concerns? 4. Do people try to provide the kind of care you would like to receive?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you know if the person feels respected? 2. How is respect considered in decisions regarding supports, services, and activities? 3. Are there any barriers that affect the outcome for the person? 4. How do you assist the person to overcome barriers to this outcome?	*1. Does the organization know what is important to the person with regard to respect?* *2. Does the organization take action to ensure that interactions with the person are respectful?* *3. Have supports need to enhance the person's self-image been identified and implemented?*

Outcome: People choose their services.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. What services are you receiving? 2. When, where and from whom do you receive the services? 3. Who decided what services you would receive? If not you, who & why? 4. Are these services the one's you want? 5. Do you have enough services? 6. Can you change services/providers if you want?	*1. Does the person select the services and/or supports that he/she receives?* *2. Do the services/supports focus on the person's goals?* *3. Does the person have choices about service providers?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly)**
1. Do you choose the services you get? More than one option? 2. Is there a way to increase your choice making ability? Do you have the support to help you in making decisions? 3. If speaking for the person: How do you know when he/she has a preference? 4. Can you ask for a different provider? Will your choice be honored? 5. Can you choose not to have a service? 6. Who recommended your doctor? 7. Do you still have the same doctor as when you entered Family Care? If not, why? 8. Do you still have the same therapist as when you entered Family Care? If not, why? 9. Do you still have the same personal care worker as when you entered Family Care? If not, why? 10. Who chooses your (barber, hair stylist, bank, grocery store, etc.)?	1. Do you receive support in order for you to choose your services? 2. If you are uncomfortable with your case manager, can you choose a new one if you wish? 3. Can you choose your providers? 4. Were you provided with options for services? 5. Were you provided with options for providers? 6. Did you get sufficient/enough/adequate help getting your services? 7. Did you have to wait to receive services? How long? Why did you have to wait? 8. Were you given options to the extent of assistance you needed to choose your services? 9. Are you able to assist with the hiring of your personal care worker? 10. Are you able to be as independent as you wish to be when choosing your services? (Do others take too much control away from you?) 11. Who chooses where you shop for groceries, who does your hair, where you bank, etc?	1. What help are you receiving? 2. When, where and from who do you receive this help? 3. How did you decide what help you would receive? 4. How was your care manager, caregivers, service providers chosen? 5. Were you given a choice in the help that is provided? Were you given more than one option? 6. Did you have enough time to make decisions? 7. Do you feel your opinions were listened to? 8. Do you have enough help to continue with your usual activities? 9. Do you know who to call if you want/need some help? If you want to change something about the help you are receiving? 10. Where do you bank, get your hair done, get spiritual support, etc?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you determine the services desired by this person? 2. How were options for services and providers presented to the person? 3. How were the person's preferences considered when presenting options? 4. If the person has limited ability/experience to make decisions, what do you do? 5. How do you assist the person to overcome barriers to this outcome?	*1. Does the organization actively solicit the person's preferences for services and providers?* *2. Does the organization provide options to the person about services and providers?* *3. Does the organization honor the person's choices about services and providers?*

Outcome: People remain connected to informal support networks.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. Who are the people in your life that you count on? 2. Who do you want to talk to or be with when you go through rough times? 3. Have you lost contact with family members or others? 4. Is the contact enough? If no, why? 5. What type of frequency of contact would you prefer?	*1. Does the person have a natural support network?* *2. If the answer to #1 is yes, what contact does the person have with people in the network?* *3. Is this contact satisfactory to the person?* *4. If the person does not have a natural support network, is this due to personal choice or due to natural circumstances?* 5. *If due to personal choice or natural circumstances, the outcome is present.*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Do you see your family members as much as you want? 2. Do you talk with family members or communicate with them by writing as much as you want? 3. How do you stay in touch with your family members and others who are most important in your life? 4. Are you able to attend family events? If no, why? 5. Do you go to family events? Weddings? Funerals? Anniversaries?	1. Have you been provided the supports to maintain contact with family and friends? 2. Do you have enough contact with your family and special people in your life?	1. Do you have contact with your family members? If not, what is the reason? Is this contact enough? 2. Do you go to family member's homes and vice versa? 3. Do you participate in family activities and events that are meaningful to you? 4. If not, why? What are the problems (transportation, need support, etc)? 5. Are there family members you feel you can count on?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you learn about the person's support network? 2. What do you do to support contact? 3. If there is no contact, what is done to assist the person to re-establish contact if desired? 4. If contact is with parents only, what do you do to expand/extend the network 5. What do you do if the extent and frequency of contact is unsatisfactory to the person? 6. Are there barriers preventing the person from remaining connected with people s/he identifies as a part of this support network? How do you assist the person to overcome these barriers?	*1. Has the person's natural support network been identified by the organization?* *2. Does the organization know the status of relationships within the person's support network?* *3. Does the organization provide support for the person's relationships within the network if needed and requested?*

Outcome: People are safe.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. What kinds of safety risks are you concerned about? In the home/community? 2. Do you feel safe at home? 3. Is there anyplace you don't feel safe? 4. What would you do if there were an emergency? 5. Do you have safety equipment? 6. Is your living environment clean and safe of health risks?	*1. Does the person live, work, and pursue leisure activities in environments that are safe?* *2. Does the person know how to respond in the event of an emergency situation?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Do you feel safe in your home? 2. Are there reasonable precautions/equipment to reduce the risk of break in? 3. Have you been taught safety strategies? 4. Are there adaptation or modifications in your home to reduce the risks of accidents? 5. What response systems are available should an accident occur? Who would help you? Would anyone know if an unfortunate even occurred? 6. Has a risk/safety assessment been done? 7. Are there neighbors who watch out for you? 8. What would you do if…..? (scenarios) 9. Who takes care of snow shoveling?	1. Do you ever feel unsafe in your home, in the community, or other setting? 2. If you were in a vulnerable situation, what would you do? (what would you do if… scenario) 3. Are you aware of the consequences of your decision to take a risk? 4. Do you need any additional adaptive equipment in order to help you feel safer? 5. Are there any options or resources that could make staying in your own home easier and safer? 6. Do you feel there are any potential risks to remaining in your home?	1. Do you feel safe at home? Have friends or family raised concern about your safety? 2. How safe do you feel when you enter or exit your home? Move from one room to another? Manage stairs? 3. Have you ever been left alone for so long that you felt unsafe? 4. Is there anywhere in the home that you do not feel safe? 5. Have you had any accidents (falls, burns)? Do you worry about falls or accidents? 6. If you fall, can you get up by yourself? 7. What would you do if there were an emergency (fire, illness, injury, or severe weather)? 8. How do you call for help? Do you know who to call for help? Do you have services or someone to help you if there is an emergency? 9. Do you have safety equipment in your home (smoke alarm, weather alert, fire extinguisher, a way to see who is at the door before it is opened)? 10. Do you feel safe in your neighborhood? 11. Are there any "ADL's" (dressing, bathing, eating) that you have difficulty with by yourself? How do you do them? Do you feel there are any safety issues with completing these tasks? Are you afraid that you might hurt yourself? 12. If you had an injury or spell of illness that made being at home unsafe, do you have a plan to ensure your safety? That you will be able to remain in your home? Do you have anyone who could help you? How would you cope?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How do you know that the person is safe? 2. How do you learn about safety issues that are of concern to the person? 3. What do you do to ensure that places where the person spends time are safe? 4. Are there any barriers to the person's safety? 5. How do you assist the person to overcome barriers to this outcome?	*1. Has the organization identified safety issues for the person?* *2. Is the person provided with supports to address identified safety concerns if needed and requested?*

Outcome: People are treated fairly.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. Have there been times when you thought you were treated unfairly or your rights were violated? 2. With whom can you talk when you have concerns about your rights? 3. Are any of your rights formally limited? If yes, did you agree to? 4. What is being done to change the situation? What assistance are you getting so you can exercise this right in the future?	*1. What rights limitation or fair treatment issues have been identifies by this person?* *2. If none, the outcome is present.* *3. If there are limitations or fair treatment issues, was due process provided?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. How informed are you about the right to file complaints/grievances? How often? 2. Do people listen when you voice a concern? 3. Is there anything you've asked for and been denied? If so, why? 4. Are you being billed for services you aren't using? 5. Do you feel you are treated fairly? Have you been treated fairly? 6. Have you ever complained or filed a complaint? Were you treated differently after you filed a complaint? In what way? Do you feel free to complain again without negative impact? 7. If you had a complaint, was anyone available to help you file one? 8. Are you paying for services that should be provided by the CMO?	1. Is there anything you have been denied? If so, why? 2. Are you being billed for services you are not using? 3. Have you ever complained or filed a complaint? Were you treated differently after you filed a complaint? In what way? Do you feel free to complain again without negative impact? 4. If you had a complaint, was anyone available to help you file one? 5. Are there any restricting rules in your life that you don't agree with?	1. Is there someone you can talk to if you have concerns about how you are being treated?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. Does the person have rights limitations? What is the reason for limitations? 2. How was it decided limitation was necessary? Who consented to limitations? 3. Who reviewed the limitation? What is the plan to remove the limitation? 4. How ling will the limitation be in place? 5. What are the barriers that affect the outcome for the person? 6. How do you assist the person to overcome barriers to this outcome?	*1. Has the organization solicited info about rights violations or fair treatment issues from the person?* *2. Have procedures for addressing the person's concerns been implemented?* *3. Are the procedures used by the organization consistent with due process principles?*

Outcome: People have the best possible health.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. Do you feel healthy? If no, what bothers you? 2. What do you do to stay healthy? 3. What health concerns do you have? 4. Are you seeing a doctor, dentist, and health care professionals? 5. Do you take medications? If so, what is it, and how does it help? 6. If you think medications, treatments, or interventions are not working, what is being done?	*1. Does the person see health care professionals?* *2. Have health care professionals identified the person's current best possible health situation, addressing any health care issues or concerns, and interventions?* *3. Have health intervention services been selected by the person in consultation with the health care professional?* *4. Have health intervention services as desired by the person been effective?* *5. If due to personal choice, the outcome is present.*

Supplemental guidance questions for members by Target Group*:

Key question for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly:**
1. Who is your primary physician? 2. If you have a health problem, whom do you tell about it? 3. Who helps you make health care decisions? 4. Over the past year, has your health condition gotten better? Remained the same? Gotten worse? Why do you feel that way?	1. How is your health? Do you have any health problems? 2. Do you have any health problems that interfere with activities you like to do or would like to do? 3. Have you ever had pressure ulcers/sores? 4. Do you have any problems getting to the bathroom or having accidents? 5. Are you able to sleep? Do you rest during the daytime? 6. Are you physically comfortable and free from pain? 7. Do you ever feel lonely? Anxious? Sad? Like life is not worth living? 8. Do you rely on alcohol or drugs? 9. Have you discussed any health or substance use issues with your doctor or someone else? 10. Do you have preventive health screenings?	1. How is your health? Do you have any health problems? How often have you been hospitalized in the past six months? Gone to the ER or emergency clinic? 2. Do you have any health problems that interfere with activities you like to do or would like to do? 3. How do you get to the doctor? Dentist? Therapist? Does someone go with you do your medical appointments? 4. Are you able to see your doctor when you need to? Do you see anyone else regarding your health (public health nurse, therapist, etc)? 5. Who do you talk to if you have a question or concern about your health or medications? 6. How do you get your medications? Do you ever forget to take your medication? Does someone help you take or remember your medications? 7. Can you tell me what medications you are taking and why? Are you taking different medications from different doctors? Does one doctor know all the medications you are taking? Do you ever take anyone else's medications? 8. Are you physically comfortable and free from pain? 9. Have you discussed feelings of sadness, depression, anxiety, etc. with your doctor or other person? 10. Do you exercise? 11. Do you get preventative care (mammograms, prostate screening, etc)? 12. What kinds of things do you eat on most days? 13. Have there been times when you have gone without food, water, or medicine?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How have you explored health issues with the person? 2. What supports does the person need to achieve or maintain best possible health? 3. Who provides the support? 4. How was this decided? 5. How do you assist the person to overcome barriers to this outcome? 6. What organizational practices, values, and activities support this outcome for the person?	*1. Does the organization know the person's definition of best possible health?* *2. Are supports provided for the person to promote and maintain best possible health if needed and requested?* *3. Does the organization respond to the person's changing health needs and preferences?* *4. Based on the answers to these questions, are there individualized supports in place that facilitate this outcome?*

Outcome: People are free from abuse and neglect.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. Do you have any complaints about how you are being treated by anyone? 2. Have you been hurt by anyone? 3. Has anyone taken advantage of you? 4. Does anyone yell or curse at you? 5. Who would you tell if someone hurt you or did something you did not like? 6. Do you know what abuse is? 7. Have you been abused?	*1. Have there been any allegations of abuse or neglect by or on behalf of the person?* *2. Is there any evidence that the person has been abused, neglected, or exploited?* *3. Is the person experiencing personal distress from a previous occurrence of abuse?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the member (input from BALTCR - elderly):**
1. Have you reported any incidents of abuse or neglect? If yes, were you protected from the abuser? Was there an investigation? Was there any follow up? 2. Would you feel comfortable reporting any incidents of abuse or neglect? 3. Who would you call if you were abused or neglected? Do you know the telephone number? 4. Have you ever been afraid while in the care of a paid caretaker? 5. Have you ever been held against your will? 6. Are you free to exit your room at any time? Your residence? 7. Do you live in a clean environment? 8. Are you free from verbal abuse? 9. Have you been abused in the past? If so, how long ago? 10. Do you feel you are treated badly? (Does the treatment need to be reported?)	1. Have you ever been left alone for long periods of time? 2. Has anyone ever kept you from having food or water? 3. Does anyone yell or curse at you, making you afraid or uncomfortable? 4. Have you ever been subject to unwanted sexual advances? Have you ever been forced to perform sexual acts you did not want to do? 5. Have you ever told anyone? Do you know who to talk to? Do you have someone you feel comfortable with that you can talk to? 6. Do you know what abuse is? *(outcome)* Has anyone explained what abuse is? *(support)* 7. Do you know what neglect is? Has anyone explained what neglect is? 8. What does your spouse/partner/child/ caregiver do when they get angry? 9. Does your spouse/partner/child/caregiver ever act in a way that frightens you? 10. Are you afraid of your spouse/partner/child/ caregiver? 11. Have you ever been punched, kicked, hit or hurt in a way by a member of your family or caregiver? Were you threatened or forced to do things you did not want to do? 12. Does anyone depend on you for money or other help (through feelings of guilt or sympathy)? 13. Has anyone who takes care of you ever pressured you for money other things of value?	1. How are things going in your relationship with your spouse/partner/child/caregivers at home? 2. What does your spouse/partner/child/ caregiver do when they get angry? Does this hurt you in any way? 3. Does your spouse/partner/child/caregiver ever act in a way that frightens you? 4. Are you afraid of your spouse/partner/child/ caregiver? 5. Have you ever been punched, kicked, hit or hurt in a way by a member of your family or caregiver? Were you threatened or forced to do things you did not want to do? 6. Have you ever been forced to do sexual acts you did not wish to do? 7. Have you ever told anyone? Do you know who to talk to? Do you have someone you feel comfortable with that you can talk to? 8. Have you ever been left alone for so long you have felt unsafe? Anxious? Worried? 9. Are there times when you do not have access to money? 10. Have people ever kept you from having food or medicine? 11. Does anyone depend on you for money or other help (through feelings of guilt or sympathy)? 12. Has anyone who takes care of you every pressured you for money or other things of value?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. Does the person understand abuse and neglect? If yes, how do you know that? 2. What has been done to inform the person? 3. What activities/practices are in place for the person to prevent abuse and neglect? 4. How do you assist the person to overcome barriers to this outcome?] 5. What organizational practices, values, and activities support this outcome for the person?	*1. Does the organization know about the person's concerns regarding abuse and/or neglect?* *2. Does the organization provide the person with information and education about abuse and neglect?* *3. Does the organization provide support for the person if there have been concerns expressed or occurrences of abuse and neglect?*

Outcome: People experience continuity and security.

Selected questions from The Council's Personal Outcomes 2000 Manual to assess outcomes:	Decision making questions:
1. How long has your support staff worked with you? 2. Is there anything you want to change? 3. What is your source of income? 4. Do you have enough money to pay your expenses? Are there things you have to do without? Is your financial sit. acceptable? 5. Renter's Insurance? Home Owners Insurance? Life insurance?	*1. What changes have occurred for the person over the past one to two years?* *2. Are changes determined by the person?* *3. Is the control over changes similar to that exercised by other people?* *4. Does the person have economic resources to meet his/her basic needs?*

Supplemental guidance questions for members by Target Group*:

Key questions for the CMO member (input from BDDS - DD):	**Key questions for the CMO member (input from BALTCR - PD):**	**Key questions for the CMO member (input from BALTCR - elderly):**
1. Are you able to sustain the life you want? 2. Do you have the same staff most of the time? 3. Are there people in your life whom you feel you can trust? 4. How many times have you moved? 5. If you complain, are you afraid you will have to move? 6. How long have you lived here? How much longer do you think you will live here? 7. Do you have enough resources/money to feel secure and get the things you need? 8. How do you deal with changes? How do others handle changes in your life? 9. Do you control most of the changes in your life?	1. Do you control the changes that occur in your life? 2. Has anyone talked to you about planning for the future? Financial planning? 3. Has anyone ever talked to you about the kind of care you would like to receive? 4. Has anyone ever talked to you about the kind of care you would like to receive at the end of your life?	1. Do you know the name of your care manager and how to contact him or her? 2. Do other people help you? Do you know how to get in touch with them? 3. Does the same person come to your house? How many caregivers have you had over the past year? Month? 4. Do you like your caregivers? Do you think your caregivers are familiar with you and your preferences? 5. Do your helpers come on time? Do they come when they are scheduled? 6. Do you feel you can change the times, dates that your helpers come? 7. Do you have family, friends, or neighbors that you can count on to provide some help or check on you from time to time? 8. Do your helpers know about the things you have done in your life and the memories or mementos that are important to you? 9. Do you have enough money to pay for expenses (food, rent, clothing, health care, insurance, transportation) and leisure activities (getting hair done, going out to lunch)? 10. Do you have insurance to protect your valuables, provide you the burial you desire? 11. Do you feel you have some control over the changes that occur in your life?

Selected questions from The Council's Personal Outcomes 2000 Manual to assess supports:	Decision making questions:
1. How are changes handled and planned for? 2. How is the importance of staff continuity defined for the person and addressed through the support process? 3. How is the sufficiency of the person's economic resources determined? 4. What supports are provided if they are insufficient? 5. How is the person assisted to obtain additional resources? 6. How does the organization ensure that the person has protection for his/her personal resources? 7. How do you assist the person to overcome barriers to this outcome?	*1. Does the organization know what is required for the person to experience continuity and security or are efforts being made to learn about the person's preferences?* *2. Are supports provided to assist the person in attaining and maintaining continuity and security?*

Appendix II: Member Outcomes by CMO

The tables below show the results for each CMO. Readers should be cautious about comparing results between the CMOs, although comparisons will be possible at a later date. These baseline results, as presented here, do not take into account the possible effects of case mix (for example, Milwaukee serves only elderly individuals, and the CMOs have different proportions of individuals with severe disabilities among their members.) In addition, comparison would be misleading because the CMOs have been in operation for varying lengths of time, and the levels of outcomes and supports in place are, at this point, still affected by the supply and quality of services in the area at the time each CMO began operation.

Fond du Lac County

115 Members Interviewed

Number of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	33	36	22	21	20	20
Privacy	40	39	29	23	29	25
Respect	37	39	23	24	19	20
Choose Services	29	31	16	19	18	19
Choose Daily Routine	46	43	22	18	24	25
Achieve Employment Objectives	31	32	19	21	17	21
Satisfied with Services	37	39	23	21	17	21
Choose Where to Live	23	36	19	22	20	19
Participate in the Community	26	34	19	19	15	19
Connected to Informal Supports	28	31	23	27	16	20
Free from Abuse & Neglect	39	26	27	16	27	17
Best Possible Health	32	40	12	22	14	22
Safe	40	41	25	20	22	19
Continuity & Security	26	26	14	15	14	10
# Interviews	**52**		**31**		**32**	

Percent of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	63.5%	69.2%	71.0%	67.7%	62.5%	62.5%
Privacy	76.9%	75.0%	93.5%	74.2%	90.6%	78.1%
Respect	71.2%	75.0%	74.2%	77.4%	59.4%	62.5%
Choose Services	55.8%	59.6%	51.6%	61.3%	56.3%	59.4%
Choose Daily Routines	88.5%	82.7%	71.0%	58.1%	75.0%	78.1%
Achieve Employment Objectives	59.6%	61.5%	61.3%	67.7%	53.1%	65.6%
Satisfied With Services	71.2%	75.0%	74.2%	67.7%	53.1%	65.6%
Choose Where to Live	44.2%	69.2%	61.3%	71.0%	62.5%	59.4%
Participate in the Community	50.0%	65.4%	61.3%	61.3%	46.9%	59.4%
Connected to Informal Supports	53.8%	59.6%	74.2%	87.1%	50.0%	62.5%
Free From Abuse & Neglect	75.0%	50.0%	87.1%	51.6%	84.4%	53.1%
Best Possible Health	61.5%	76.9%	38.7%	71.0%	43.8%	68.8%
Safe	76.9%	78.8%	80.6%	64.5%	68.8%	59.4%
Continuity & Security	50.0%	50.0%	45.2%	48.4%	43.8%	31.3%

La Crosse County

178 Members Interviewed

Number of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	48	44	28	28	42	43
Privacy	60	48	31	30	54	50
Respect	50	45	36	31	52	46
Choose Services	34	38	22	25	32	39
Choose Daily Routines	56	50	30	31	52	54
Achieve Employment Objectives	32	37	25	25	40	41
Satisfied with Services	49	45	30	30	40	44
Choose Where to Live	43	45	26	30	49	49
Participate in the Community	46	45	24	23	29	33
Connected to Informal Supports	43	44	23	30	32	38
Free from Abuse & Neglect	52	32	37	22	56	36
Best Possible Health	50	47	16	17	25	47
Safe	56	44	34	29	55	45
Continuity & Security	35	15	26	16	23	22
# Interviews	**71**		**40**		**67**	

Percent of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	67.6%	62.0%	70.0%	70.0%	62.7%	64.2%
Privacy	84.5%	67.6%	77.5%	75.0%	80.6%	74.6%
Respect	70.4%	63.4%	90.0%	77.5%	77.6%	68.1%
Choose Services	47.9%	53.5%	55.0%	62.5%	47.8%	58.2%
Choose Daily Routines	78.9%	70.4%	75.0%	77.5%	77.6%	80.6%
Achieve Employment Objectives	45.1%	52.1%	62.5%	62.5%	59.7%	61.2%
Satisfied With Services	69.0%	63.4%	75.0%	75.0%	59.7%	65.7%
Choose Where to Live	60.6%	63.4%	65.0%	75.0%	73.1%	73.1%
Participate in the Community	64.8%	63.4%	60.0%	57.5%	43.3%	49.3%
Connected to Informal Supports	60.6%	62.0%	57.5%	75.0%	47.8%	56.7%
Free From Abuse & Neglect	73.2%	45.1%	92.5%	55.0%	83.6%	53.7%
Best Possible Health	70.4%	66.2%	40.0%	42.5%	37.3%	70.1%
Safe	78.9%	62.0%	85.0%	72.5%	82.1%	67.2%
Continuity & Security	49.3%	21.1%	65.0%	40.0%	34.3%	32.8%

Milwaukee County

98 Members Interviewed

Number of Outcomes Met/Supports Provided

	Frail Elderly	
	Outcomes	*Supports*
Treated Fairly	73	80
Privacy	95	86
Respect	75	77
Choose Services	42	69
Choose Daily Routines	89	88
Achieve Employment Objectives	76	86
Satisfied with Services	73	90
Choose Where to Live	76	77
Participate in the Community	64	79
Connected to Informal Supports	74	87
Free from Abuse & Neglect	85	72
Best Possible Health	45	64
Safe	81	67
Continuity & Security	57	52
# Interviews	**98**	

Percent of Outcomes Met/Supports Provided

	Frail Elderly	
	Outcomes	*Supports*
Treated Fairly	74.5%	81.6%
Privacy	96.9%	87.8%
Respect	76.5%	77.6%
Choose Services	42.9%	70.4%
Choose Daily Routines	90.8%	89.8%
Achieve Employment Objectives	78.6%	87.8%
Satisfied With Services	73.5%	91.8%
Choose Where to Live	78.6%	79.6%
Participate in the Community	65.3%	80.6%
Connected to Informal Supports	75.5%	88.8%
Free From Abuse & Neglect	85.7%	73.5%
Best Possible Health	45.9%	65.3%
Safe	82.7%	68.4%
Continuity & Security	58.2%	53.1%

Portage County

74 Members Interviewed

Number of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	27	29	12	14	18	24
Privacy	31	29	11	12	22	20
Respect	28	29	12	13	21	20
Choose Services	17	19	11	13	20	23
Choose Daily Routines	26	26	9	12	23	23
Achieve Employment Objectives	23	28	14	15	12	17
Satisfied with Services	26	28	9	14	16	18
Choose Where to Live	19	26	10	13	20	19
Participate in the Community	25	24	9	10	16	20
Connected to Informal Supports	21	24	9	10	17	25
Free from Abuse & Neglect	28	25	15	12	22	15
Best Possible Health	26	29	10	10	11	20
Safe	27	23	14	13	21	17
Continuity & Security	22	17	9	9	11	7
# Interviews	**33**		**16**		**25**	

Percent of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	81.8%	87.9%	75.0%	87.5%	72.0%	96.0%
Privacy	93.9%	87.9%	68.8%	75.0%	88.0%	80.0%
Respect	84.8%	87.9%	75.0%	81.3%	84.0%	80.0%
Choose Services	51.5%	57.6%	68.8%	81.3%	76.0%	92.0%
Choose Daily Routines	78.8%	78.8%	56.3%	75.0%	92.0%	92.0%
Achieve Employment Objectives	69.7%	84.8%	87.5%	93.8%	48.0%	68.0%
Satisfied With Services	78.8%	84.8%	56.3%	87.5%	64.0%	72.0%
Choose Where to Live	57.6%	78.8%	62.5%	81.3%	80.0%	76.0%
Participate in the Community	75.8%	72.7%	56.3%	62.5%	64.0%	80.0%
Connected to Informal Supports	63.6%	72.7%	56.3%	62.5%	68.0%	100.0%
Free From Abuse & Neglect	84.8%	75.8%	93.8%	75.0%	88.0%	60.0%
Best Possible Health	78.8%	87.9%	62.5%	62.5%	44.0%	80.0%
Safe	81.8%	69.7%	87.5%	81.3%	84.0%	68.0%
Continuity & Security	66.7%	51.5%	56.3%	56.3%	44.0%	28.0%

Richland County

27 Members Interviewed

Number of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	8	10	4	4	8	8
Privacy	13	12	6	4	8	6
Respect	10	11	3	2	7	5
Choose Services	8	11	2	4	4	6
Choose Daily Routines	11	11	5	6	6	6
Achieve Employment Objectives	9	11	3	3	6	5
Satisfied with Services	12	11	5	6	7	8
Choose Where to Live	9	11	6	6	6	8
Participate in the Community	9	10	4	4	4	5
Connected to Informal Supports	6	10	2	4	7	4
Free from Abuse & Neglect	11	9	3	4	6	4
Best Possible Health	8	11	4	5	1	6
Safe	9	8	5	5	6	5
Continuity & Security	5	7	2	3	2	3
# Interviews	**13**		**6**		**8**	

Percent of Outcomes Met/Supports Provided

	Developmental Disability		Frail Elderly		Physical Disability	
	Outcomes	*Supports*	*Outcomes*	*Supports*	*Outcomes*	*Supports*
Treated Fairly	61.5%	76.9%	66.7%	66.7%	100.0%	100.0%
Privacy	100.0%	92.3%	100.0%	66.7%	100.0%	75.0%
Respect	76.9%	84.6%	50.0%	33.3%	87.5%	62.5%
Choose Services	61.5%	84.6%	33.3%	66.7%	50.0%	75.0%
Choose Daily Routines	84.6%	84.6%	83.3%	100.0%	75.0%	75.0%
Achieve Employment Objectives	69.2%	84.6%	50.0%	50.0%	75.0%	62.5%
Satisfied With Services	92.3%	84.6%	83.3%	100.0%	87.5%	100.0%
Choose Where to Live	69.2%	84.6%	100.0%	100.0%	75.0%	100.0%
Participate in the Community	69.2%	76.9%	66.7%	66.7%	50.0%	62.5%
Connected to Informal Supports	46.2%	76.9%	33.3%	66.7%	87.5%	50.0%
Free From Abuse & Neglect	84.6%	69.2%	50.0%	66.7%	75.0%	50.0%
Best Possible Health	61.5%	84.6%	66.7%	83.3%	12.5%	75.0%
Safe	69.2%	61.5%	83.3%	83.3%	75.0%	62.5%
Continuity & Security	38.5%	53.8%	33.3%	50.0%	25.0%	37.5%